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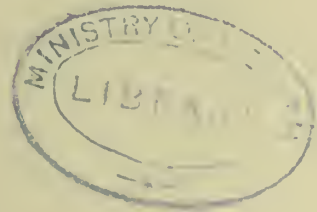
Annual Report

of the

Medical Officer of Health

for the year

1952



PUBLIC HEALTH OFFICERS

Medical Officer of Health

John Sleigh, M.B., Ch.B.(Aberd.), D.P.H.(Edin.)

Chief Sanitary Inspector

A. R. Tarrant, M.R.San.I., M.S.I.A.

Additional Sanitary Inspector

R. K. Crow, M.R.San.I., M.S.I.A., M.R.I.P.H.H.

To the Mayor and Members of the Andover Borough Council:

Mr. Mayor, Ladies and Gentlemen,

I have the honour to present my Annual Report for the year 1952.

In 1951* over 3,250,000 patients were treated in hospitals, 173,000 more than in 1950 and 322,000 more than in 1949. The number of whole-time consultants rose from 1,310 in 1949 to 1,605 in 1951, and of part-time consultants from 3,879 to 4,274. During that same period of two years the total medical and dental staff in the hospital service went up from 8,954 whole-time members to 10,245, and from 20,280 part-time members to 23,281. Nearly 14,000 more hospital beds were brought into use, and hospital nursing staff increased by over 13,000. There was no halt in the persistent rise in both the number and cost of doctors' prescriptions, which in number went up from 217,000,000 in 1950 to 228,000,000 in 1951, and in average cost from 3s 1d. at the beginning of 1950 to about 3s 11d. each at the end of 1951. Five doctors' prescriptions were issued on the average in one year for every man, woman, and child in the country. The number of prescriptions rose from 10 $\frac{3}{4}$ million in the first month of the Service to not far short of 17 million a month in the summer of 1951, and in January of that year, during an influenza epidemic, it reached the astonishing figure of just on 29 million.

When this Report was published some nine months ago the account of it given in the Press and on the wireless gave the impression that it was a great testimonial to the National Health Service, but I would submit that there are other ways of looking at the matter than this. Let us start by examining the question of cost.

Cost of the National Health Service in Millions of Pounds

	1950-51	1951-52	1952-53	1953-54
Local Health Authorities	16.8	18.6	21.2	21.6
General Practitioner Service	47.4	48.4	57.6	58.2
Pharmaceutical Dental and Ophthalmic Services	106.4	94.4	67.6	73.4
Regional Hospital Boards	251.1	274.3	296.0	297.1
Total	421.7	435.7	442.4	450.3

It will be remembered that four years ago the then Government decided to set a limit of £400 million on the amount that was to be spent annually on the National Health Service. Two years ago the present Government imposed certain charges for the pharmaceutical, dental, and supplementary ophthalmic services, in a further attempt to keep the cost of the Service within bounds. The above figures show just how successful both Governments have been in achieving their object. The total spending on the Service is somewhere about 3 $\frac{1}{2}$ per cent of the total national spending on goods and services, and unless further charges are imposed so that less and less of the Service remains to be paid for from taxation, the cost will continue to rise year by year and will continue to account for an increasing proportion of the total national spending.

Percentage of the Total spent on the four Services in each year

	1950-51	1951-52	1952-53	1953-54
Local Health Authorities	4.0	4.3	4.8	4.8
General Practitioner Service	11.2	11.1	13.0	12.9
Pharmaceutical, Dental and Ophthalmic Services	25.2	21.7	15.3	16.3
Regional Hospital Boards	59.6	62.9	66.9	66.0
Total	100.0	100.0	100.0	100.0

There are two points here to which I would like to draw attention. The first is the quite disproportionately enormous amount spent on the Hospital Service (two-thirds of the total) and the quite disproportionately small amount spent on the Local Health Authority Service (less than 5% of the total.) The Hospital Service makes the least contribution to the promotion of health and the prevention of disease, being concerned almost entirely with the treatment of disease, the Local Health Authority Service makes the greatest contribution to the promotion of health and the prevention of disease. The other point is that the only effect of the charges made for the pharmaceutical, dental and supplementary ophthalmic services was to divert the money into the ever-willing maw of the hospital service. As the amount of money and percentage of the total devoted to these three services was reduced, so was that devoted to the hospital service increased. Over the four years the combined totals of the two in terms of money were £357.5, £368.7, £363.6, and £370.5 millions, and in terms of percentages 84.8, 84.6, 82.2, and 82.3. It is the hospital service that is the cause of the enormous cost, and of the increasing cost, of the National Health Service.

* Report of the Ministry of Health 1st April 1950 to 31st December 1951, Part I.

These astronomical figures for numbers sick, and for the cost of their treatment, are at the same time a very clear indication that whatever the death rate may be there is certainly something very far wrong with the sickness rate. Furthermore the fact that the numbers sick and the cost of their treatment is rising year by year seems to suggest, as many people have believed all along, that a healthy community cannot be achieved by treating the sick, and in fact that increased facilities for treatment will only whet the demand for still greater facilities.

In previous annual reports I have quoted Dr. Ffrangcon Roberts, who seems to have a clearer idea than anyone else of the fact that the treatment of disease is something that will inevitably increase. Here is another quotation from Dr. Roberts: "The phenomenal increase in the progress of medical science, with its attendant increase in cost, far outstrips any possible increase in production by which alone it can be financed." So long as we try to achieve health by treating disease, so long must we expect to spend an increasing proportion of our national income on the treatment of disease, for the increase in scientific knowledge is something which will continue at an accelerating rate and the cost of the treatment of disease will increase as research and therapeutics become ever more elaborate and expensive. All the time we find more methods of diagnosis and new means of treatment, necessitating more hospitals, more nurses, and more doctors, and longer training for these. If it were economically possible for this inevitable and increasing acceleration to continue, the whole population would ultimately be working a 24-hour day looking after the sick.

The attempt four years ago to put a ceiling on expenditure on the National Health Service and the further attempt two years ago to curtail expenditure by making certain charges, indicated that the economic aspects of the present situation were beginning to be appreciated. I do not know whether it is yet realised that if we try to achieve health by treating the sick, we must expect to spend at an increasing rate year by year, but even from year to year as the cost of the Service rises, the voice of the economists is going to be heard more and more. If the present policy continues, the National Health Service is going to make an increasingly excessive demand on our production and on our labour force. If the Service gets more then other things must get less, and many people would say that food, shelter and education, to give only three examples, were more important than the National Health Service. I have discussed elsewhere in this report the effect of the diminishing birth rate on the proportion of producers in the community and figures on this subject can be found on page 7, but without going into detail here, the fact is that the proportion of producers is steadily contracting, and that it would be better that they should be in productive employment than in non-productive employment as in the National Health Service. Furthermore, in doctors and nurses, the Service demands material of above-average quality so that its call on our manpower resources is greater than mere numbers suggest. Exactly the same arguments apply to the demand that the Service makes on our production and on our material resources. Again, I have indicated elsewhere in this report (page 3) the particular difficulties of our economic situation with reference to Housing, that Housing must take its place in the queue of priorities behind home food production and exports to pay for imported food, and that there is a buyers' market for exports and a sellers' market for food. I suppose half as much again is spent on the National Health Service as on Housing, and I am equally sure that Housing should be before, not after, the Service.

There is the problem. What then is the solution? Dr. Roberts suggests that we should develop some system of priorities, when treatment would be provided in proportion to the recipient's ability to return, in the form of service, its cost to the community. There is however another answer to this problem than that of allocating treatment only where there will be a corresponding return. The doctrine of original disease has come to be accepted by Man, and it never occurs to us to question whether Nature might not have meant us to be healthy. We accept sickness and disease as inevitable and devote our medical services almost entirely to their investigation and treatment. We never stop to question why the incidence of disease is so different in different countries, or even in different parts of the same country. This subject and suggested cause and remedy, are discussed on page 13.

Our research should be into health and its attainment, not into disease and its treatment. The treatment of a disease in one individual does nothing to prevent another from acquiring the same condition, nor even to prevent the first from becoming ill again, when he returns to the environment (of which food is the most important part) which made him take ill in the beginning. It may be argued that such research will be as complex and unrewarding as is our present research. But I believe that what we are going to find in every case is that it was where we went astray from Nature that we were wrong, and that it is only in the direction of aberrations from Nature that we need look for the cause of disease.

* "Medical Officer" 1953, I, 239.

Housing

Once again it is appropriate to include some words on Housing in the Annual Report. The Medical Officer of Health is concerned with all matters affecting the health of the community and housing is still by far the most important of these and so far as can be seen will continue to be for an indefinite period. But whereas food rationing for example affects all members of the community, the housing shortage affects only those who require to be rehoused and the likelihood of the politicians taking the same degree of interest in the housing shortage as in food rationing is lessened, because only a minority of the electorate are concerned with the one, whereas the whole electorate are concerned with the other. 209,000 houses were built in England and Wales in 1952, which is a welcome improvement over the figure for 1951, 172,000. However I repeat once again that there is a very long way to go before we reach the figure for 1938, the last prewar year, which figure was 344,000 for England and Wales. Houses are needed far more now than they were then, and if 344,000 were built in 1938, it should be possible to build more than 209,000 in 1953. I would also repeat once more that 183,000 houses are required each year for replacement purposes, and that out of the 209,000 that were built last year only 26,000 could really be regarded, from the point of view of the community as opposed to that of individual families, as being additional houses. No wonder lists of prospective Council tenants increase steadily.

However as I tried to indicate last year, the problem of housing our people is primarily economic and I do not think the implications of this are fully realised. We are told there is a dollar shortage as if this was due to bad luck, if not to the inexplicable workings of high finance. The plain truth is that there is a dollar shortage because we cannot earn enough dollars by our exports to the dollar area to pay for our imports from the dollar area. We buy more from the dollar area than the dollar area buys from us and so we have an adverse trade balance. The purpose of devaluation was to make our goods more attractive in the dollar area by reducing their price in dollars by 25%, but it also meant that we had to export 33% more to the dollar area in order to earn the same amount of dollars as before, and so to be able to buy the same amount of goods. Our first requirement is food, and our first objective must be to expand home food production, (it would be better to develop marginal land in this country and get more beef and dairy products than to spend money in tropical Africa trying to produce ground nuts and poultry with no result), but after that the second call on our resources must be to produce exports to pay for imports and for the raw materials needed to manufacture further exports. Housing must expect a smaller slice of the cake than it did before the war. A poor man has to spend more of his income on food than a rich one. If we need 183,000 houses a year for replacements and if we cannot build as many houses as we would like, then perhaps some people will have to do without, unless we build sub-standard houses which would be wasting materials and labour and making no contribution to solving the housing problem. The politicians are not inclined to look beyond the life of the current Parliament, and short-term considerations are liable to have preference over long-term ones, but the housing problem is as serious as ever, and is by no means solved yet.

Last year I said something about housing allocation and I do not think that some further comment on this subject is out of place. Some Authorities operate a Points Scheme, others do not. Unless houses are allocated on the basis of groups of applicants small enough for those allocating them to have a mental picture of the circumstances of all those applying, it is difficult to see how a Points Scheme can be dispensed with, and this criterion is only likely to be met in the case of a very small Municipal Borough or Urban District or in that of a parish. Allocation on the basis of a parish is not entirely satisfactory because it is difficult to estimate the respective requirements of the various parishes in a Rural District and because in any case it may not be possible to find sites adequate for the requirements of the parish, or in fact, sites at all in every parish. Points Schemes do therefore seem to be of real value in most instances, and if it is found that families come to the top of the list who manifestly do not need rehousing, or that families do not come to the top of the list who manifestly do need rehousing, so that discretionary points have to be awarded fairly frequently, then there is something wrong with that Scheme in particular, not with Points Schemes in general. It should not be necessary to award discretionary points too frequently and the fact that discretionary points have to be awarded in a deserving case means that it is possible to ignore a deserving case by not adding the points. Houses should be allocated primarily on a basis of need, and sufficient points should be allocated for the factors relevant to need to ensure that they are not outweighed by the factors not relevant to need. There is no obligation on a Council to house families whom it would not welcome, and there is no need for a Points Scheme which will prevent such families reaching the top of the list. Exactly the same considerations apply whether a Points Scheme has been adopted or not, and such weight should be given to such factors as

overcrowding, sharing a house, insanitary conditions, ill health, and children, as to ensure that they are not outweighed by such other factors as war service, residence, employment, and date of application. It has been recommended by the Central Housing Advisory Committee that the first list of factors should be regarded as basic and the second list should be used only in distinguishing between families who are equal with one another as far as the first list is concerned. Once again I would like to stress particularly the case of families with children. There appears to be no justification for housing families without children before families with children. A family's difficulty in obtaining accommodation is in direct proportion to the number of children, and families without children should not be considered until those with children have been satisfied, unless their present accommodation is to be used for families with children, and other things being equal, families should be considered in order of number of children.

There are at present in occupation in this Municipal Borough, 11 ex Services Huts and 10 houses which are the subject of a prewar clearance order or of a prewar undertaking not to use for human habitation, and are occupied under licence, or which are the subject of a postwar undertaking not to use for human habitation. A survey by the Medical Officer of Health and Chief Sanitary Inspector suggested that a further 193 houses were incapable of repair at reasonable expense. It is now more than seven years since the end of the war and the Huts are no longer fit to live in. At the same time the unfit houses are deteriorating, and in my view the time has now come to consider setting a definite limit to the period within which all these tenants should be rehoused, and rehousing the appropriate proportion each year. The longer a decision is delayed the larger will be the task, because each year a further quota of unfit houses will be added and will require treatment in the same way.

Finally it may be of interest to compare the number of houses built in Andover Municipal Borough (population 15,390) since the end of the war with the number which might have been expected had houses been built at the same rate as in all towns of 25,000 and under (population 6,422,770). 172,814 permanent houses were built by public and 34,834 by private enterprise and 15,463 temporary houses were built by public enterprise (total 223,111) up to the end of 1952, and on that basis 414 permanent houses might have been built by public and 84 by private enterprise and 37 temporary houses might have been built by public enterprise (total 535) in Andover Municipal Borough. The actual figures were 415 permanent houses built by public and 81 by private enterprise and 50 temporary houses built by public enterprise (total 546) giving 100%, 96%, 135%, and 102% respectively of what might have been expected, or 2% above average overall.

The figures for 1952 alone however, are less satisfactory. 28,576 permanent houses were built by public and 5,356 by private enterprise (total 33,932) and on that basis, 68 permanent houses might have been built by public and 13 by private enterprise (total 81) in Andover Municipal Borough. The actual figures were 57 permanent houses built by public and 16 by private enterprise (total 73) giving 84%, 123%, and 90% respectively of what might have been expected, or 10% below average overall.

I am indebted to Mr. A.R. Tarrant, M.R.San.I., M.S.I.A., Chief Sanitary Inspector, for his assistance in the preparation of this Report. (Sections C, D, and E.)

I have the honour to be,

Mr. Mayor, Ladies and Gentlemen,

Your obedient servant,

John Leigh.

Section A Statistics and Social Conditions of the Area

(1951 figures in brackets)

Area (in acres)	6,381	(6,381)
Registrar General's estimate of resident population	15,430	(15,390)
Number of inhabited houses according to Rate Books	4,047	(3,970)
Rateable value	£107,204	(£104,125)
Sum represented by a penny rate	£447	(£434)

Chief Industries carried on in the area

Below are given Ministry of National Insurance figures of numbers employed, obtained from the Ministry of Labour. It is not possible to give figures for the Borough of Andover as Ministry of National Insurance areas are based not on existing Local Government areas, but on the towns and the areas of country draining naturally into them. The figures given are for the area of the Andover office of the Ministry of National Insurance, which area comprises:

Andover Municipal Borough
 Andover Rural District
 Hurstbourne Priors, Laverstoke, St. Mary Bourne, Whitchurch, and Portals only in Overton, in Kingsclere and Whitchurch Rural District.
 Broughton, Houghton, Leckford, Longstock, Nether Wallop, Over Wallop, and Stockbridge, in Romsey and Stockbridge Rural District.

Paper making and Printing	1,729
Agriculture	1,452
Building and Civil Engineering	1,193
Distributive trades	1,084
Local and National Government	1,068
Engineering, Garages, etc.	941
Transport	679
Professions	539
Food and Drink, etc.	497
Woodwork etc.	386
All others	2,057
TOTAL	11,625

Extent of unemployment

This compares very favourably with that for England and Wales (0.6% as against 1.8%)

Vital Statistics
(1951 figures in brackets)

	Andover M B		England & Wales	
<u>Births</u>	Rates per 1000		Home Population	
Live births	15.5	(14.9)	15.3	(15.5)
Still births)	0.39	(0.32)	0.35	(0.36)
)	24.5(a)		22.6(a)	
<u>Deaths</u>				
All Causes	9.6	(11.2)	11.3	(12.5)
Typhoid and paratyphoid	0.00	(0.00)	0.00	(0.00)
Whooping cough	0.00	(0.00)	0.00	(0.01)
Diphtheria	0.00	(0.00)	0.00	(0.00)
Tuberculosis	0.32	(0.19)	0.24	(0.31)
Influenza	0.00	(0.19)	0.04	(0.38)
Smallpox	0.00	(0.00)	0.00	(0.00)
Acute poliomyelitis (including polioencephalitis)	0.00	(0.00)	0.01	(0.00)
Pneumonia	0.13	(0.32)	0.47	(0.61)
<u>Notifications (Corrected)</u>				
Typhoid fever	0.00	(0.00)	0.00	(0.00)
Paratyphoid fever	0.00	(0.00)	0.02	(0.02)
Meningococcal infection	0.00	(0.00)	0.03	(0.03)
Scarlet fever	0.32	(0.26)	1.53	(1.11)
Whooping cough	1.69	(7.99)	2.61	(3.87)
Diphtheria	0.00	(0.00)	0.01	(0.02)
Erysipelas	0.06	(0.06)	0.14	(0.14)
Smallpox	0.00	(0.00)	0.00	(0.00)
Measles	0.06	(15.66)	8.86	(14.07)
Pneumonia	0.06	(0.00)	0.72	(0.99)
Acute poliomyelitis (including polioencephalitis)				
Paralytic	0.19	(0.00)	0.06	(0.03)
Non-Paralytic	0.00	(0.00)	0.03	(0.02)
Food poisoning	0.00	(0.00)	0.13	(0.13)
Puerperal pyrexia	0.00(a)	(17.09)(a)	17.87(a)	(10.66)(a)
<u>Deaths</u>	Rates per 1000 Live Births			
All causes under 1 year of age	16.7	(4.4)	27.6	(29.6)
Enteritis and diarrhoea under 2 years of age			1.1	(1.4)

(a) Per 1000 Total (Live and Still) Births.

Vital Statistics

Birth Rate

The Birth Rate for 1952 (15.5 per 1000) was 0.2 per 1000 above that for England and Wales (15.3 per 1000). If the rate is standardised to allow for the differing age and sex distribution of the population in Andover Municipal Borough as compared with that in England and Wales, it is increased to 16.1 per 1000. While the fact that the standardised birth rate is higher than that for England and Wales is an indication that more babies were born than might have been expected on the basis of the age and sex distribution of the population in Andover Municipal Borough as compared with that in England and Wales, the fact that the standardised birth rate is higher than the crude birth rate is an indication that the age and sex distribution of the population in Andover Municipal Borough tends towards fewer births as compared with that in England and Wales.

Until recently, as a result of the Registrar General's refusal to publish net reproduction rates, I had thought that the number of children being born was only about three quarters that necessary to maintain the population at its present level, and that when the present increase in the expectation of life ceased, as it must do when all die of old age, a position from which we are not very far distant today, the population would fall by a quarter in each generation. Certainly before the war, when the birth rate was about the same as it is today, that was the position which existed, but in spite of an appeal to the Registrar General, he refused to give figures for the net reproduction rate in recent years. However as a result of recent correspondence in the "Medical Officer"^{*} the Registrar General has now revealed that the difference between the net reproduction rate and the effective reproduction rate, which is the rate published by the Registrar General, is much less than had been thought and that in fact improvement in mortality has been such that births are around the 100 per cent replacement level and that a dramatic fall in population is not at present foreseen.

This however is only half the story, as a birth rate which before the war was sufficient only to provide 75 per cent replacement can only become sufficient to provide 100 per cent replacement at the cost of a very considerable shifting in the balance of the population towards the older age groups, and this in fact is what is happening. Whereas in 1931 the percentages of men and women aged 15 - 34 were 33.8 and 33.0 respectively, in 1951 they were 27.9 and 26.9 respectively, and whereas in 1931 the percentages of men and women aged 65 and over were 6.6 and 8.1 respectively, in 1951 they were 9.3 and 12.3 respectively.[†] In the same way, whereas in 1951 22% of the population were aged under 15, 67% aged 15 - 65, and 11% aged over 65, in 1971 20% will be aged under 15, 66% aged 15 - 65, and 14% aged over 65.[‡] These changes may not seem very great but their significance is more clearly seen when they are viewed in the light of the observations of the Ministry of National Insurance.^{**} In 1953-54 retirement pensions will cost nearly £350 million a year out of a total expenditure from the fund of £540 million, but in 25 years time, retirement pensions will cost nearly £700 million out of expenditure of £950 million. The income from the fund will remain constant at about £530 - £550 million a year, but expenditure will begin to outstrip income by 1954-55, and from then onwards the gap will increase rapidly to £100 million a year by 1957-58, and £420 million a year by 1977-78. The effect of the increasing number of retirement pensioners is illustrated by the fact that while the immediate cost of the increase in pensions provided by the Act of 1952 is £30 million a year, it will be nearly double that amount in 25 years time.

It is easily seen therefore that the burden on the decreasing proportion of producers will become steadily heavier as the years go by. It might be said that the answer would be to produce more children, but that would result in increasing our population, and we are hard put to it to find buyers for our exports and so to pay for the food and raw materials to convert into exports, that we must have or 20,000,000 of our population whom we cannot feed will starve. The trouble is that people are living too long (viewed from the economic point of view) and it is not entirely surprising that one speaker at the Royal Sanitary Institute Congress should have made a passing reference to euthanasia.[†] Personally I cannot see how euthanasia except for incurable disease, could ever become an accepted policy, but at any rate something will soon have to be done about the age of retirement. It seems completely

* "Medical Officer" 1953 I 225 and 236.

† Census 1951 Great Britain. One per cent Sample Tables Part I.

‡ "Public Health" 1952-53. 58.

** Report of the Ministry of National Insurance for the Year 1951.

* "Medical Officer" 1953 108

unreasonable for example that women whose expectation of life is five years longer than that of men (70.88 as against 65.84)[§], should retire five years earlier, and a start might well be made by making the age of retirement the same for both sexes. Increasing the age of retirement beyond 65 for both sexes seems attractive, but while many people are useful citizens at 80, there are many others who are only too ready for retirement at 65. Making 65 the fixed age avoids the making of invidious distinctions. There is also the question of promotion of younger people being retarded by the retention of older people in their posts, which could perhaps be overcome by those over 65 being retained in subordinate employment, and the far wider question of national policy in all fields being influenced by the increasing preponderance of the elderly which already seems to be the case in the amount of welfare work done among the aged as compared to that done among the young. This matter of the ageing of our population is something of which the ultimate effects are quite unforeseeable. Public health and therapeutic medicine have enabled men to live longer. In primitive communities this has resulted in an increase of population which is straining available food resources to the uttermost, in highly civilised communities lowered reproduction rates have restrained this population increase, but have produced the problems of ageing populations of which I have tried to give some indication.

Death Rate

The Death Rate for 1952 (9.6 per 1000) was 1.7 per 1000 below that for England and Wales (11.3 per 1000). If the rate is standardised to allow for the differing age and sex distribution of the population in Andover Municipal Borough as compared with that in England and Wales it is reduced to 9.5 per 1000. While the fact that the standardised death rate is lower than that for England and Wales is an indication that fewer deaths occurred than might have been expected on the basis of the age and sex distribution of the population in Andover Municipal Borough as compared with that in England and Wales, the fact that the standardised death rate is lower than the crude death rate is an indication that the age and sex distribution of the population in Andover Municipal Borough tends towards more deaths as compared with that in England and Wales.

Infant Mortality Rate

The Infant Mortality Rate for 1952 (16.7 per 1000) was 10.9 per 1000 below that for England and Wales (27.6 per 1000). No significance should be attached to a rate of this size for a small authority.

Analysis of Mortality and Case Rates for Certain Infectious Diseases

No significance can be attached to the rates given for this authority as the population is too small. It is hoped however that it will be of some interest to compare them with those for England and Wales. The whooping cough and measles case rates for this authority for this year are low and for last year are high. This is due to the fact that although these diseases occur more or less equally each year for the country as a whole, they occur in each area every two to four years for whooping cough and every two years for measles as it takes that period for the level of immunity in the population to fall as a result of new births to the point at which an epidemic can recur. The three cases of poliomyelitis which are represented by the case rate of 0.19 occurred in males aged 7, 13, and 20 on 8th, 16th, and 21st August in Croye Close, South Street, and Old Winton Road, in other words, the cases were separated in time and place and had no obvious contact with one another. I have no doubt that during the month of August there was a very high carrier rate for poliomyelitis and also that there was a very large number of sub-clinical cases in addition to the three clinical cases. One was not paralysed, one slightly, and one severely, and there were no deaths.

The following table[‡] may be of interest as showing the importance of poliomyelitis relative to other infectious diseases.

	<u>Number of deaths</u>	<u>Death rate per million</u>
Influenza	15,809	361
Tuberculosis, respiratory	12,031	275
Tuberculosis, other forms	1,775	41
Gastro-enteritis	1,457	33
Whooping cough	456	10
Measles	317	7
Meningococcal infections	298	7
Poliomyelitis, acute	217	5

[§] Registrar General's Quarterly Return No. 416 Fourth Quarter 1952.

[‡] Annual Report of the Chief Medical Officer of the Ministry of Health for the Year 1951.

Vital Statistics 1951 - 1952

Year	Popu- lation	%	E & W	Births	B R	E & W	Deaths	D R	E & W	IM	I M R	E & W
1951	15390	100	100	229	14.9	15.5	172	11.2	12.5	1	4.4	29.6
1952	15430	100.3	100.3	239	15.5	15.3	148	9.6	11.3	4	16.7	27.6
Total				468	30.4	30.8	320	20.8	23.8	5	21.1	57.2
Average					15.2	15.4		10.4	11.9		10.6	28.6

Population 1952 15430

Population 1951 15390

Total Increase 40

Births 1951 - 52 468

Deaths 1951 - 52 320

Natural Increase 148

Total Increase 40

Natural Increase 148

Immigration -108

Vital Statistics 1951 - 52

I have not this year repeated the table giving Population, Population expressed as a percentage of the 1938 Population, Population of England and Wales expressed as a percentage of the 1938 Population, Births, Birth Rate, Birth Rate of England and Wales, Deaths, Death Rate, Death Rate of England and Wales, and Infant Mortality, Infant Mortality Rate, Infant Mortality Rate of England and Wales, for each year from 1938, the last complete prewar year. This table can be consulted if desired, in last year's report. Instead I include a table giving the same information but taking 1951, the census year, as the base year, so that there is only one other year, 1952, to compare with it this year.

Population

The percentage increase in population for Andover Municipal Borough for 1951-52 was exactly the same as that for England and Wales, but the total increase in population of 40 was made up of a natural increase of 148 masking an emigration of 108. There are of course so many Army and Air Force men and their families in Andover, that fluctuations of this nature can only be expected over so short a period.

Births

The Birth Rate for Andover Municipal Borough for 1952 showed an increase above that for 1951, and whereas in 1951 it had been below that for England and Wales, in 1952 it was above that for England and Wales. Over the two years taken together however, the average was below that for England and Wales.

Deaths

The Death Rate for Andover Municipal Borough for 1952, showed a decrease below that for 1951. In both years the Death Rate was below that for England and Wales.

Infant Mortality

The Infant Mortality Rate for a relatively small population such as Andover Borough can be expected to vary widely from year to year and no significance need be attached to the increase in the rate between 1951 and 1952, which only represents an increase from one death to four. At the same time however, it does appear that the average infant mortality in Andover Municipal Borough is lower than that in England and Wales, and the Infant Mortality Rate is the most important indication of the health of the community.

National Assistance Act 1948

Section 47 - Removal to suitable premises of persons in need of care and attention.

No action has been taken by the Council under this Section.

Food Poisoning Outbreaks

No outbreaks of Food Poisoning occurred during 1952.

Clean Food Campaigns

The Film Shows and Discussions on Health Education including Clean Food, which had been offered hitherto to a number of existing organisations and given to those that accepted the offer, had to be discontinued when a charge for the screening of films by the Central Office of Information was introduced in June. A most valuable service which was highly appreciated by the Medical Officer of Health and by those who enjoyed it, was thus the victim of the present Government's economy drive.

<u>Live Births</u>	<u>Male</u>		<u>Female</u>		<u>Total</u>	
Legitimate	107	(116)	124	(103)	231	(219)
Illegitimate	1	(2)	7	(8)	8	(10)
Total	108	(118)	131	(111)	239	(229)

<u>Still Births</u>	<u>Male</u>		<u>Female</u>		<u>Total</u>	
Legitimate	3	(2)	3	(3)	6	(5)
Illegitimate	0	(0)	0	(0)	0	(0)
Total	3	(2)	3	(3)	6	(5)

<u>Deaths of Infants under 1 year of age</u>	<u>Male</u>		<u>Female</u>		<u>Total</u>	
Legitimate	4	(1)	0	(0)	4	(1)
Illegitimate	0	(0)	0	(0)	0	(0)
Total	4	(1)	0	(0)	4	(1)

<u>Deaths of Infants under 4 weeks of age</u>	<u>Male</u>		<u>Female</u>		<u>Total</u>	
Legitimate	4	(0)	0	(0)	4	(0)
Illegitimate	0	(0)	0	(0)	0	(0)
Total	4	(0)	0	(0)	4	(0)

<u>Deaths</u>	<u>Male</u>		<u>Female</u>		<u>Total</u>	
Tuberculosis, respiratory	4	(1)	1	(2)	5	(3)
Tuberculosis, other	0	(0)	0	(0)	0	(0)
Syphilitic disease	1	(0)	0	(0)	1	(0)
Diphtheria	0	(0)	0	(0)	0	(0)
Whooping cough	0	(0)	0	(0)	0	(0)
Meningococcal infections	0	(0)	0	(0)	0	(0)
Acute poliomyelitis	0	(0)	0	(0)	0	(0)
Measles	0	(1)	0	(0)	0	(1)
Other infective and parasitic diseases	0	(0)	0	(0)	0	(0)
Malignant neoplasm, stomach	0	(1)	3	(1)	3	(2)
Malignant neoplasm, lung, bronchus	6	(2)	2	(0)	8	(2)
Malignant neoplasm, breast	0	(0)	2	(4)	2	(4)
Malignant neoplasm, uterus	0	(0)	4	(1)	4	(1)
Other malignant and lymphatic neoplasms	10	(10)	7	(6)	17	(16)
Leukaemia, aleukaemia	1	(0)	1	(0)	2	(0)
Diabetes	0	(0)	0	(1)	0	(1)
Vascular lesions of nervous system	7	(9)	8	(10)	15	(19)
Coronary disease, angina	7	(12)	7	(9)	14	(21)
Hypertension with heart disease	0	(1)	2	(2)	2	(3)
Other heart disease	14	(21)	21	(29)	35	(50)
Other circulatory disease	4	(0)	0	(2)	4	(2)
Influenza	0	(0)	0	(3)	0	(3)
Pneumonia	1	(2)	1	(3)	2	(5)
Bronchitis	6	(4)	0	(4)	6	(8)
Other diseases of respiratory system	2	(0)	0	(0)	2	(0)
Ulcer of stomach and duodenum	2	(1)	0	(1)	2	(2)
Gastritis, enteritis, and diarrhoea	2	(1)	0	(2)	2	(3)
Nephritis and nephrosis	2	(0)	2	(1)	4	(1)
Hyperplasia of prostate	2	(1)	0	(0)	2	(1)
Pregnancy, childbirth, abortion	0	(0)	0	(2)	0	(2)
Congenital malformations	2	(0)	0	(0)	2	(0)
Other defined and illdefined diseases	8	(6)	4	(11)	12	(17)
Motor vehicle accidents	0	(2)	0	(0)	0	(2)
All other accidents	1	(0)	1	(1)	2	(1)
Suicide	0	(2)	0	(0)	0	(2)
Homicide and operations of war	0	(0)	0	(0)	0	(0)
 All Causes	 82	 (77)	 66	 (95)	 148	 (172)

Food and Health

In the Annual Report of the Chief Medical Officer of the Ministry of Health for the year 1951, it is stated that 68,446 persons died from vascular lesions of the nervous system, as compared with 64,703 in 1950, that 58,309 persons died from coronary disease and angina, as compared with 54,755 in 1950 (this is described as an alarming and perplexing increase), that 5,630 persons died from ulcer of stomach and duodenum, as compared with 5,100 in 1950, that 3,703 persons died from diabetes as compared with 3,684 in 1950, and that 1,927 persons died from leukaemia and aleukaemia, as compared with 1,832 in 1950. In 1951 thirteen times as many schoolchildren died of cancer (207) as of diphtheria (16).^{*} At the beginning of the century, many countries showed less than 5% of all deaths attributable to cancer and malignant tumours. By 1947 in great contrast, most of the nations studied had one in seven to nine deaths reported as due to cancer, with the percentage exceeding 10% in many cases.[†] The diseases mentioned above can all be described under the broad classification of degenerations of tissue. Our tissues are made up of the food we eat, and the presumption is therefore that there is something wrong with that food.

Cancer of the breast is ten times as frequent in England and America as in Japan, Cancer of all types is much commoner in London than elsewhere in this country, comparing especially unfavourably with rural areas. In Switzerland the death rate for cancer is 1,629 per million, but in Ceylon it is only 900, and of this, 800 is attributed to the local habit of betel-chewing, and cancer of the stomach is rare.[‡] Primitive communities from four continents have been found to be almost completely free from hypertension, for instance, the blood pressure remaining stationary or falling with advancing age.^{**} The inference is that it is something in civilized diet which is responsible for the increase in degenerative disease, and it is hard to avoid the conclusion that the explanation is that our diet is becoming increasingly processed, sophisticated, and adulterated.

Recently, the city analyst of Birmingham found that samples of meringue mixture were composed of methyl cellulose, an artificial product which is made from cotton and which has a superficial resemblance to white of egg, but which has no food value. He also found that meringue powder was compounded of an allied substance ethyl methyl cellulose, together with potato starch. The Ministry of Food had been consulted about and had approved the composition, description, and labelling of these products. An example is given of beans obtained from a reputable store, which when placed in warm water refused to germinate and began to give off a strange odour. Upon enquiry at the store, it was found that these articles had been treated with some kind of preservative at the place abroad from which they had been imported. Experiments have been made in the use of an antibiotic (subtilin) as a food preservative. Grave dangers might arise from the use of antibiotics for such purposes. Some of them may be toxic. Continuous use may interfere with beneficial intestinal bacteria. The ingestion of them may create strains of resistant bacteria, and interfere with their therapeutic efficiency. Certain chemicals are used for destroying weeds, and are alleged to be selective in that they destroy the weeds but not the food plant which is growing in the field. The question is, what residues are left in the plant? Recently, certain chemicals have been introduced in animal husbandry. An example of this is the extensive use in the United States and to some extent in this country, of the implantation into chickens of an artificial hormone known as stilboestrol. The effect of this substance is to interfere with normal sexual development in a manner somewhat similar to that resulting from the older process for producing capons. A larger quantity than usual of fat is deposited under the skin and the appearance of the fowl to the consumer is improved, although it is alleged that the quality of the meat and of the fat is interfered with. What effect this may produce upon consumers is difficult to say. The substance is supposed to be implanted in the neck of the chicken which is not normally used for human consumption. An interesting sidelight is thrown upon this by the fact that in the United States the discarded heads and necks were under the advice of the Department of Agriculture, sold to mink farmers for feeding their animals with the result that the mink became infertile and were unable to reproduce. The loss was so serious that a Bill was passed through Congress to compensate the mink farmers. The above examples are taken from a paper given by Lord Douglas at a sessional meeting which I attended of the Royal Sanitary Institute.

^{*} "Medical Officer" 1953, I, 36.

[†] "Public Health" 1951-52, 196.

[‡] "Medical Officer" 1952, II, 64.

^{**} British Medical Journal, 1953, I, 1320.

It may be that our diet is responsible for more than an increase in the death rate from degenerative diseases. A recent survey² of sick absence in the Metropolitan police disclosed that the rate of sick absence was considerably higher post war than prewar, being 4.67 per cent in 1951 compared to 2.66 per cent in 1938. During the post war years under investigation there was a 52 per cent average increase in the number of sick absence spells per man compared to prewar. Younger policemen showed the most increase in frequency of sickness. The average length of sick leave increased by 16 per cent. The rate of sick absence increased in men under 50 by about 70 per cent and in older men by about 40 per cent.

In this country the Ministries responsible for our food are those of Food and of Agriculture and Fisheries. Now the objectives of these two Ministries must be to produce as much food as possible and food which the consumer finds acceptable, and these objectives must conflict with that of the effect of food on health. It would be much better if the responsibility for all questions involving the addition of unnatural chemicals to food rested with the Ministry of Health. Practice in the United States is much ahead of that in this country. There is in the United States a large and important department called the Food and Drugs Administration which is responsible for this question of the addition of chemicals to food, and this provides the explanation for progress there. In this country, the only organisation is the toxicological research unit of the Medical Research Council, but its objectives are quite different and much more limited. The position is that we are in the undignified position of having to rely on the decisions arrived at in the United States before policy or action can be determined here. It is not as if the questions at issue were small and of rare occurrence. Questions of great public interest are constantly coming up, and the Food and Drugs Administration is very active. The establishment of a similar department in this country is long overdue.

There is more however to this question of food than ensuring that it is fresh, natural, and wholesome, and has not been so treated as to do harm. There is also the matter of how it has been grown. An examination of the work in India of Sir Albert Howard¹ proves that disease and pests in plants and crops grown in their proper climate can be entirely eradicated by ensuring that the soil upon which they are reared receives adequate supplies of organic material in the form of plant and animal waste. He went further and demonstrated that the eradication of disease in cattle and livestock was a practicable possibility when these are reared and nurtured on land and on crops which have been organically treated in the same way. He actually allowed, on repeated occasions, his own cattle to rub noses with cattle in neighbouring fields suffering from foot and mouth disease, and on no occasion did his cattle take the disease. There is a body of farmers today in this country who have proved that if they maintain their land in first class condition by organic means, they are enabled to remain entirely immune to diseased crops, and to such scourges as foot and mouth disease, tuberculosis, contagious abortion, and fowl pest, all of which are indices of bad husbandry of the land.

The work of another great man, Sir Robert McCarrison³, again in India, is very relevant to this subject. He noted the Hunza tribe, which he gave as an example of splendid positive health. He observed that they and the Sikhs were long-lived, vigorous in youth and age, capable of great endurance, and enjoying a remarkable freedom from disease in general. They were moreover possessed of a cheerful countenance. He further observed that they lived very close to the land and obeyed nature's law of returning to their soil every vestige of organic waste matter. He noted in startling contrast, the Madrassis of the South, who were disease-ridden and of poor physique, with a depressed and quarrelsome outlook on life. McCarrison set to work with colonies of rats and fed one colony on the Sikh diet of fresh wholemeal cereal grain, dairy produce, eggs, pulses, and a little meat, and another separate colony on the Madrassi diet of white bread, margarine, white sugar, jam, and meat. The rats on the Sikh diet remained in excellent health, with healthy coats and immunity to disease, and lived happily together, while the rats on the Madrassi diet were stunted in growth, had poor coats, were subject to such diseases as duodenal ulcers, respiratory catarrhs, and miscarriages, and were quarrelsome to the extent of cannibalism. McCarrison subsequently fed further colonies of rats on diets typical of many of the various races in India and experienced in each such colony the same diseases as were prevalent in those races, and in total practically every major disease experienced in mankind.

* Monthly Bulletin of the Ministry of Health 1953, 42.

1 Howard A (1945) Farming and Gardening for Health or Disease.

3 McCarrison R (1944) Nutrition and National Health.

Smoking and Cancer of the Lung

The statistical investigation of the relationship between smoking and cancer of the lung on which I reported in my last two annual reports, has been followed by a further one^{*} by the same authors, covering many parts of the country (the earlier one was confined to London, and the adjacent counties) and involving more detailed inquiries into smoking habits, and some extracts from this investigation, which confirmed the earlier one, are given hereunder. Whereas among a control group of 1,357 men and 108 women without cancer of the lung 61 (4.5%) of the men and 59 (54.6%) of the women were non-smokers, among a group of 1,357 men and 108 women with cancer of the lung only 7 (0.5%) of the men and 40 (37.0%) of the women were non-smokers. Whereas among the control group only 166 (12.2%) of the men and 0 (0.0%) of the women, had smoked 25 or more cigarettes a day over the preceding 10 years, among the group with cancer of the lung 331 (24.4%) of the men and 14 (13.0%) of the women had done so. It was calculated that above the age of 45 the risk of cancer of the lung was 21 times as great among men and 13 times as great among women who had smoked 25 or more cigarettes a day over the preceding 10 years as among non-smokers. A similar survey of smoking habits of doctors dying from cancer of the lung and from other cancers is quoted in the British Medical Journal.[†] In the lung cancer group only 58% smoked on average less than 15 cigarettes or their equivalent a day, as compared with 43.4% in the other cancer group. As regards the heavy smokers, in the lung cancer group 33.8% smoked on average 35 or more cigarettes or their equivalent a day as compared with only 12.7% in the other cancer group. In a letter in the British Medical Journal[‡] it is stated that whereas the chances of dying of cancer of the lung before 55 are 1 in 1000 for a non-smoker, they are 1 in 70 for a person who smokes 15-25 cigarettes a day and 1 in 50 for one who smokes 25-50.

The actual figures for deaths from cancer of the lung in England and Wales are no less startling.^{**} Whereas in 1931, 1,635 men and 651 women (total 2,286) died of cancer of the lung, in 1951 11,166 men and 2,081 women (total 13,247) died of cancer of the lung. Whereas in 1931, cancer of the lung represented 6% of all cancer in men and 2% in women, in 1951 it represented 25% of all cancer in men and 5% of all cancer in women. In a letter in the British Medical Journal[†] it is suggested that correlating the rising curve of tobacco consumption with that of deaths from lung cancer over the last 25 years, the annual increase of approximately 1,000 deaths will continue until 1965 by which time nearly 25,000 people will die each year.

It has been suggested that the increase in cancer of the lung is due to improved diagnosis. But it is pointed out^{**} that the number of cases is still increasing by about 1000 per year although it is most unlikely that improved diagnosis could account for this, that mortality in males has increased by 3 times and in females by 2 times since 1931, although diagnostic facilities are equal for both sexes, that considerable differences exist in the death rates of towns which have similar diagnostic facilities, and that professional workers, including doctors, give rates rather below the average although here the availability of diagnostic facilities would presumably be at a maximum.

Air pollution has been suggested^{††} as a cause, but rates in cities are never more than twice as high as in the country (which could be explained by the heavier smoking of city dwellers) whereas as indicated above, rates for smokers are more than 20 times as high as for non-smokers. Cancer of the lung does occur occasionally in non-smokers, and it is suggested therefore that smoking cannot be the cause of cancer of the lung, but whereas the cancer which occurs in smokers is a squamous carcinoma, that which occurs in non-smokers is an adenocarcinoma.^{**} This point was also made by Mr. F.E. Chin, Thoracic Surgeon, Thoracic Surgical Unit, Southampton Chest Hospital at a meeting which I attended of the Southern Branch of the Society of Medical Officers of Health.

Meanwhile Mr. Iain MacLeod, (Minister of Health) says that he is not aware of any generally accepted cause or causes of the increase in the number of cases of cancer of the lung, and Miss Pat Hornsby-Smith (Parliamentary Under-Secretary, Ministry of Health) says that she accepts the statistical relationship between smoking and cancer of the lung, but not that it is causal, though how she can do this, I cannot understand. If it is statistically significant it is not coincidental. It is impossible that cancer of the lung could cause smoking, and although the possibility that both could be due to a third factor seems at first sight attractive the longer one thinks about it the less likely this appears.

* British Medical Journal 1952, II, 1271.

† British Medical Journal 1953, I, 986.

‡ British Medical Journal 1953, I, 1105.

** Annual Report of the Chief Medical Officer of the Ministry of Health for the Year 1951.

+ British Medical Journal 1953, I, 161.

†† British Medical Journal 1952, II, 982.

Section B. General Provision of Health Services for the Area.

National Health Service Act 1946
Local Health Services under Part III

In paragraph 20 of Ministry of Health circular 118/47, it was recommended that all counties should be sub-divided according to local health requirements, that in each Sub-Division the County Health Committee would use its powers under paragraphs 6 and 7 of Part II of the Fourth Schedule to the Act to appoint a Sub-Committee on which the Councils of County Districts comprising the Sub-Division would be represented, and to which would be delegated the day to day administration in the Division of the Part III (Local Health Authority) Services of the National Health Service Act, and that under the County Medical Officer, executive charge of these Services in the Division would be taken either by an existing Assistant County Medical Officer, preferably one who was also Medical Officer of Health of one or more of the districts constituting the Division, or by the Medical Officer of Health of one of these Districts who would be appointed to the staff of the County Medical Officer. The County Council as the Local Health Authority would of course retain its responsibility for policy and finance unimpaired, but to day to day administration the Sub-Committee would bring the local interest and knowledge which are so desirable in such personal services.

In paragraph 7 of Ministry of Health circular 27/51 county councils were again recommended to have regard to the advantages which might be expected to flow from a plan, which besides providing for a single officer to hold the office of Medical Officer of Health for two or more county districts where this was appropriate, also provided for him to be employed part-time in county council services and so to help to administer the personal health services of the county council in the area in addition to discharging the duties which fell to him as County District Medical Officer of Health. The Minister was sure that such arrangements were in the interests of the local services as well as of the officers themselves, because they secured to those services the help of Medical Officers experienced in the administration of both kinds of local health services - environmental and personal. The marked growth in recent years of arrangements of this kind was itself sufficient testimony of their value and practicability.

The Minister of Health at the Annual Dinner of the Society of Medical Officers of Health on 23rd October, 1952, said, "But I am perhaps less happy in my mind about the relationship of local authorities and local people to the Health Service than any other aspect of it. Here we have a number of problems not only unsolved, but completely untouched. There is the problem for example whether the personal health services should or should not be managed one tier down from where they are at present administered."

The recommendations of the Delegation Sub-Committee of the Local Government Manpower Committee which were published by the Committee and which were endorsed by the then Minister of Local Government and Planning, included recommendations similar to those of Ministry of Health circular 118/47. (Local Government Manpower Committee, Second Report, Appendix X, Section G, Health.)

A memorandum agreed by the Council of the Society of Medical Officers of Health, which was published by the Society, stated that the Society of Medical Officers of Health was in favour of decentralisation of National Health Service Part III Functions by county councils wherever practicable, that the Society considered that such decentralisation should be to Sub-Committees of County Health Committees (as authorised by the Fourth Schedule Part II, paragraphs 6 and 7), which should be responsible for day to day administration of some or all of the Part III Services, that the Medical Officer appointed to serve the Sub-Committee normally had other duties to perform and might be Medical Officer of Health for one or more of the county districts in the area, that so far as the Medical Officer's duties under Part III of the National Health Service were concerned he acted as a senior member of the staff of the County Medical Officer, and that policy, finance and establishment were retained as functions of the central committee.

In paragraph 28 of the Minutes of Report No 7/1952 of the Health Committee of the Association of Municipal Corporations, the Association, in commenting on the Memorandum of the Society of Medical Officers of Health, stated that they had always been opposed to the transfer of maternity and child welfare and other local health functions from the councils of county districts to county councils under Part III of the National Health Service Act 1946, as these services were regarded as being of such a personal and intimate nature that they should be dealt with by local authorities in the closest contact with the persons for whom the service was provided,

and that as no provision was made for the direct delegation of functions to county district councils the Association favoured the implementation of the recommendations of the Delegation Sub-Committee of the Local Government Manpower Committee to the fullest extent until such time as amending legislation was passed to place the service on a more satisfactory basis.

In a Study on "Autonomy and Delegation in County Government, Delegation in Education and Local Health Administration", prepared for the Institute of Public Administration, by Miss Emmeline Cohen, it was stated (page 62 paragraph 2) - "In the West Riding the area officer, who is also M.O.H., is looked upon as a social worker par excellence, seeking to strike at the root of disease by changing the living conditions of the people. To attend a local conference is to see this concept take shape in an impressive way. The area officer, sanitary inspector, senior health visitor, senior home-nurse, and T.B. welfare visitor between them know intimately the streets and the people in them and can pinpoint problems relating to families or conditions and bring cohesion into local policy. The officer in a division so organised is the captain of a team and the team is a coherent unit in the county's health organisation. At a conference of this kind, questions of liaison with other parts of the service come up and those incapable of local solution are referred to the county council." Further favourable comment on the working out in practice of what Miss Cohen calls a new local focus in local health administration can be found on pages 64 paragraph 3, and 78 paragraph 3.

A large proportion of the counties in England and Wales have carried out the recommendation of the Minister of Health on formation of divisions with Divisional Medical Officers, including two counties as dissimilar as the West Riding with 31 Divisions of an average population of 51,251 at the 1951 census and 31 Divisional Medical Officers, and Cornwall with 7 areas of an average population of 49,373 at the 1951 census and 7 Area Medical Officers, but no such sub-division has taken place in Hampshire. Charge of duties under Section 26 (Vaccination and Immunisation) is taken by the Medical Officer of Health but charge of duties under Sections 22 (Care of Mothers and Young Children) 23 (Midwives) 24 (Health Visitors) 25 (Home Nursing) 27 (Ambulances) 28 (Prevention of Illness, Care and After Care) and 29 (Domestic Help) remains with the County Medical Officer. The District Health Sub-Committee has advisory functions only in connection with these Sections with the exception of Section 27 (Ambulances), but the officers carrying out these services come directly under the control of the County Health Committee and are in no way answerable to the District Health Sub-Committee.

The area of the three Councils for which I am Medical Officer of Health is admirably suited for a scheme of divisional administration. Its population was 50,050 at the 1951 census, which is similar to that which has been found appropriate in other counties. The northern and western boundaries of the area are formed by the Berkshire and Wiltshire County Boundaries and so cannot be altered, and the area forms a natural geographical unit of the kind most appropriate outside the major conurbations for the administration of these particular services.

Following the receipt of Ministry of Health circular 27/51, discussions were held between the three Councils, and at a meeting of representatives of the three Councils held on 20th March, 1952, a resolution in favour of divisional administration was passed unanimously, which resolution was subsequently adopted by each of the three Councils and by the two District Health Sub-Committees of the County Council covering the area of the three Councils. A deputation from the three Councils was received by a sub-committee of the County Council's Health Committee on 18th September, 1952, but the County Council refused to consider the scheme put forward. The three Councils then approached the Ministry of Health and a meeting between the interested parties took place at the Ministry on 24th March, 1953, at which meeting, the County Council representatives having accepted the principle of decentralised administration contained in paragraph 20 of Ministry of Health circular 118/47, it was agreed that further discussions should take place between the three Councils and the County Council. The three Councils then prepared a draft scheme on the basis of paragraph 20 of circular 118/47 for discussion with the County Council, but the County Council have refused to discuss it. There the matter rests, except that on the day the County Council's refusal was received, your Medical Officer of Health submitted his resignation to the three Councils on being appointed a Divisional Medical Health Officer under the Nova Scotia Provincial Government. It must not be supposed, and I do not think is likely to be supposed, that the coincidence of events was fortuitous.

Section 26 (Vaccination and Immunisation)

This is therefore the only one of the Part III (Local Health Authority) Services under the National Health Service Act on which I am able to report.

Notification of birth cards received by the County Medical Officer from the Health Visitors are sent to the Medical Officer of Health, who prepares Diphtheria Immunisation Record Cards from them, and these form a Diphtheria Immunisation Card Index. Consent cards received by parents from the Health Visitors are sent to the Medical Officer of Health who sends the corresponding Diphtheria Immunisation Record Cards to the general practitioners, and they perform the immunisation. A Diphtheria Immunisation Clinic is also conducted by the Medical Officer of Health with the assistance of the Health Visitors at the Health Centre, Junction Road, Andover at 11 a.m. on the first Saturday in the month for those children whose parents wish them to be immunised by him.

Diphtheria Immunisation
Annual Return for year ended 31st December, 1952.

	Age							
	at date of final injection (as Regards A) or of reinforcing injection (as regards B)							
	Under 1	1	2	3	4	5 to 9	10 to 14	Total
A. Number of children who completed a full course of primary immunisation in the authority's area (including temporary residents) during the year ended 31 Dec. 1952	11	158	36	9	11			225
B. Number of children who received a secondary (re-inforcing) injection (i.e. subsequently to primary immunisation at an earlier age) during the year ended 31 Dec. 1952.						241	77	318

As regards the secondary (reinforcing) injections (i.e. subsequently to primary immunisation at an earlier age), a letter was prepared by the Medical Officer of Health giving details of the advisability of primary and reinforcing immunisation and requesting return of an attached consent form, giving details of who it was desired should carry out the immunisation, and of the child's immunisation state. Copies of this letter were sent to the Head Teachers of all Primary Schools for distribution to children aged 5 and 10. Consent forms completed by the parents were returned by the Head Teachers to the Medical Officer of Health and were examined to see whether the child required reinforcing immunisation. Where the parent had requested that the Medical Officer of Health should carry out the immunisation, copies of a letter requesting the parent to take or send the child to the Immunisation Clinic were sent to the Head Teachers of all Primary Schools for distribution to the children concerned. Where the parent had requested that the general practitioner should carry out the immunisation, Diphtheria Immunisation Record Cards or Diphtheria Immunisation Reinforcing Injections Record Sheets were prepared and sent to the general practitioner, with payment on a per capita or sessional basis respectively, depending on the number to be immunised. Arrangements for all sessions were made by the Medical Officer of Health. This has worked very well.

Immunisation in Relation to Child Population

Number of children at 31 Dec. 52. who had completed a course of immunisation at any time before that date. (i.e. at any time since 1 Jan. 38.)

Age at 31 Dec. 52	Under 1	1	2	3	4	5 to 9	10 to 14	Total
i.e. Born in year	1952	1951	1950	1949	1948	1943-1947	1938-1942	Under 15
Number immunised	13	171	263	119	227	644	26	1463

Diphtheria Notifications and Deaths in Relation to Immunisation during the year 1952

Nil

I regret that I am not able this year to include the information about the percentages who have been immunised of the various age groups of children in this district, as compared with the County as a whole, which information has been contained in previous reports, as the Registrar General has ceased supplying the figures for numbers of children in the various age groups in the district, on which figures estimation of these percentages depend. In his letter giving this information the Registrar General states that figures for Counties will continue to be supplied, and that Medical Officers of Health should be able to derive an estimate of these percentages from local infant welfare or school medical records or by special surveys of sections of the child population and both these points are worthy of some comment.

As regards the statement that figures for Counties will continue to be supplied, it is the case that vaccination and immunisation was the only part of the Personal Health Services which was carried out by all County Districts before the passing of the National Health Service Act although other parts were carried out by some County Districts, and it is the one part of the Personal Health Services which is still devolved to County Districts by Counties to any extent over the country generally. Accordingly variations in the degree of success achieved in carrying out these duties are between one County District and another rather than between one County and another, and it would be of much more value to Medical Officers of Health to have the figures which would enable them to compare County District with County District, rather than to have only those which enable them to compare County with County.

As regards the suggestion that Medical Officers of Health should be able to derive an estimate of these percentages in one or other of a number of different ways, it is precisely because different Medical Officers of Health are likely to use different ways in their efforts to arrive at these percentages, and because even when they use the same way their methods will vary as will local circumstances, that figures for different County Districts, while they may be of some value to the Medical Officers of Health of each County District alone, will be of little value as a basis of comparison between County Districts. It is extremely doubtful whether the effort involved in making these estimates will really be worth while.

There is however another wider issue involved, on which I should also like to comment. This is at least the third blow in the last three years to the position of the Medical Officer of Health. Other Medical Officers of Health may recall other examples, but it is not out of place to mention the two which come most readily to mind in addition to the example quoted above.

Last year the Minister of Health announced that it would no longer be necessary for Medical Officers of Health to keep a Tuberculosis Register, although it was hoped that they would still do so. Expressed in other words this seems to mean that Medical Officers of Health will still be expected to keep a Tuberculosis Register, although they will no longer get credit for doing so. This Medical Officer of Health at any rate continues to keep a Tuberculosis Register, so long as he is permitted to, as he regards it as an essential part of his duty to the community if not to the Minister of Health.

The previous year the Minister of Health announced that leprosy was to be notifiable not to the Medical Officer of Health, but to the Minister. Leprosy of course is not common in this country, although there have been two recent cases in Wiltshire, but it is the reason given for this action that is so remarkable. Apparently this procedure is in the interests of secrecy. Medical Officers of Health, it seems, cannot be trusted to keep such information to themselves.

This Medical Officer of Health at any rate finds it hard to avoid the suspicion that consciously or unconsciously, a policy is under way which will ultimately cut him off from all his sources of information as a guardian of the Public Health without, so far as can be seen, putting anything else in his place.

Some Thoughts on Diphtheria Immunisation

Last year I included some words on the Decline in Diphtheria Immunisation which in general was consequent on an unjustified scare about the connection between immunisation and subsequent poliomyelitis in the inoculated limb, but which in particular appeared from figures which I quoted to have been due to a large decline in the immunisations carried out by Local Authorities, with at the same time no decline in the immunisations carried out by general practitioners. This reverse appears now to have been restored, as the figure for the first half of 1952, 287,000, compares favourably with those for the whole of 1951 and 1950, 497,000 and 433,000, and is in strict agreement with that for the whole of 1949, 574,000. The figure for the whole of 1952 is not yet available, as the Minister of Health issued his information for the annual propaganda campaigns two months earlier this year, presumably in the hope of getting such campaigns over by the middle of the year as if the connection between immunisation and poliomyelitis is of any importance, it has been shown^{*} that the incidence of poliomyelitis rises from a minimum at the beginning of July to a maximum at the end of September and falls again to a minimum at the end of December.

The emphasis in this year's campaign appears to be more on getting children immunised early, now that the number of children immunised has been restored, and some comments on this topic are therefore not out of place. Hitherto the consensus of opinion has been that the presence in the infant's body of antitoxin derived from the mother made it inadvisable to immunise in the first six or eight months of life, and as many mothers had lost touch with child welfare centre or general practitioner by that time, it became more difficult to bring the children in for immunisation and more were lost altogether. There seems now to be less emphasis on this factor and immunisation as early as three[†] or even two[‡] months is now being suggested. It is emphasised that younger children are relatively less liable to reactions following immunisation than older children, and that the dose can therefore be correspondingly larger, and that in particular a dose of 0.5c.c. was likely to be sufficient to overcome the maternal antitoxin[‡] to which dose objections on the score of possible reactions were ill-founded. A further point made^{***} was that the incidence of poliomyelitis was less in the first months of life than later and that here was a further argument for earlier immunisation.

Two interesting points arise from this discussion. In the first place, if the child can be immunised while the mother is still bringing it to the child welfare centre or general practitioner, it will be easier to bring it in for immunisation and fewer children will be lost altogether. In the second place the possibility of combining diphtheria immunisation with whooping cough immunisation becomes much greater. Whooping cough is essentially a great killer in early infancy and the chief argument against combining the two prophylactics has been that the correct date for whooping cough immunisation was too early for diphtheria immunisation, and the correct date for diphtheria immunisation was too late for whooping cough immunisation. It has been stated[†] that the combination of several antigens in mixed vaccines produces immunity titres greater than those which can be obtained by separate inoculation of each antigen and that here is a further argument for combined immunisation.

On the subject of immunisation against a number of different infectious diseases, it might be held that the chief limiting factor is the patience and co-operation of the average mother. Many people would say that it was unreasonable to expect her to take steps to have her child protected against more than three different diseases, and that if this was the case, thought would have to be given to deciding which three were the most important. Many Medical Officers of Health still lament that vaccination against smallpox is not still compulsory, (although voluntary immunisation against diphtheria, because of the greater importance of the latter to the community, is far more successful than compulsory vaccination against smallpox ever was) but if it is accepted that protection against three infections is all that can be asked for, surely diphtheria, whooping cough, and tuberculosis have a prior claim over smallpox, particularly when it is remembered that the evidence is that it is general public health measures that are responsible for the control of smallpox, and not vaccination, which in the face of an outbreak serves mainly to cloud the issue.

* Monthly Bulletin of the Ministry of Health and the Public Health Laboratory Service 1953, 2.

† British Medical Journal 1952, II, 1011.

‡ British Medical Journal 1952, II, 1012.

*** Information Digest 1952, II, 54.

+ Information Digest 1952, II, 55.

Section F Prevalence of, and Control over Infectious and other Diseases

Final numbers according to Sex and Age after Corrections of Cases of Infectious and other Notifiable Diseases notified during the year ended 31st December, 1952.

	Scarlet Fever			Whooping cough			Acute poliomyelitis			Measles		
							Paralytic			Non-Paralytic		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Under 1 year				1		1					1	1
1 - 2 years				6	2	8						
3 - 4 years				2	8	10						
5 - 9 years	3	2	5	2	5	7	1		1			
10 -14 years							1		1			
15 -24 years							1		1			
25 and over												
Age unknown												
Total (All ages)	3	2	5	11	15	26	3		3		1	1

Acute pneumonia Erysipelas

M F Total M F Total

Under 5 years						
5 -14 years						
15 -44 years	1		1			
45 -64 years				1		1
65 and over						
Age unknown						
Total (All ages)	1		1	1		1

Infectious Diseases

As already mentioned, the three cases of poliomyelitis occurred in males aged 7, 13, and 20, on 8th, 16th, and 21st August, in Croye Close, South Street, and Old Winton Road, in other words the cases were separated in time and place and had no obvious contact with one another. I have no doubt that during the month of August, there was a very high carrier rate for poliomyelitis and also that there was a very large number of sub-clinical cases in addition to the three clinical cases. One was not paralysed, one slightly, and one severely, and there were no deaths.

Once again I would like to draw attention to the importance of whooping cough as a cause of death in young children, especially infants, and to the practicability of action to put an end to this situation. Within the last year the predominance of whooping cough among the infections of childhood has become more widely appreciated and I propose to quote one or two extracts on the subject. Since 1946 deaths from whooping cough have exceeded those from smallpox, scarlet fever, measles, and diphtheria added together, and as a cause of infant deaths from infection it comes after the two rather ill-defined groups of bronchitis-pneumonia and diarrhoea-enteritis.^{*} In 1950 whooping cough was responsible for as many infant deaths as measles, scarlet fever, diphtheria, poliomyelitis, encephalitis and meningococcal infections combined. At present amongst communicable conditions, it comes only after the heterogenous groups of bronchitis-pneumonia and diarrhoea-enteritis as a cause of death in infants. In comparison with measles and scarlet fever - the latter once a notorious killer - whooping cough presents a case fatality rate which is about five times that of the other diseases.[†] The actual case fatality rates for measles, scarlet fever and whooping cough for 1951 were 0.05%, 0.08%, and 0.27%, so that for 1951 the case fatality rate for whooping cough was three times that for scarlet fever and five times that for measles.^{**} Whooping cough is not only the chief killer among the childhood infections, it is also responsible for much later ill health. Mr. E.F. Chin, Thoracic Surgeon, Thoracic Surgical Unit, Southampton Chest Hospital, speaking at a meeting which I attended of the Southern Branch of the Society of Medical Officers of Health, said that in 80% of cases of bronchiectasis (lung abscess) there was a definite history of chronic productive cough after the onset of whooping cough, and stressed also the importance of the damage which was done when atelectasis (lung collapse) occurred during whooping cough. These two points have also been stressed by Dr. H.J. Parish. Finally a follow-up of 39 children who had suffered from whooping cough disclosed that 9 had mental or physical defects and that a further 6 had had marked cerebral symptoms while in hospital.[‡]

Whooping cough therefore stands out above all others and I repeat once more some figures from a report on the statistical investigation of immunisation against the disease.[‡] Over a two to three year period of observation 149 of the 3801 vaccinated children developed whooping cough, whereas 687 of the 3757 unvaccinated children developed whooping cough, giving attack rates per 1000 child months of 1.45 and 6.87 respectively, and a reduction in the disease of 78%. Among children exposed to whooping cough in their own homes, the attack rates were 18.2% in the vaccinated and 87.3% in the unvaccinated groups. The cases that occurred in the vaccinated were on the average less severe and of shorter duration than those in the unvaccinated children. During the two to three year periods of observation there was no evidence of a waning in the degree of protection afforded by the vaccines. Five vaccines were tested of which much the most effective were two prepared by the Michigan Department of Health, although the other three were also of value. The attack rates in home exposures with the Michigan vaccines were only 7.3% and 8.9% (as against 87.3% in the unvaccinated groups) giving a reduction in the disease of 91.5%. The report on the further comparative investigations which as I have mentioned in my last two reports have been taking place, has not yet been published, but it is hoped that it will soon be possible to undertake a campaign similar to that already undertaken for diphtheria immunisation, and that the Public Health Service will be able to take the same part in the second campaign as it has done in the first. As I have mentioned in the section of my report dealing with Diphtheria Immunisation, the objections to early immunisation against diphtheria seem less strong than heretofore, early immunisation will ensure fewer children being missed, and the two vaccines produce a better immunity given together.

^{*} Monthly Bulletin of the Ministry of Health and the Public Health Laboratory Service 1953, 12, 92.

[†] Monthly Bulletin of the Ministry of Health and the Public Health Laboratory Service 1953, 12, 98.

[‡] Information Digest 1953, I, 104.

^{**} Annual Report of the Chief Medical Officer of the Ministry of Health for the Year 1951.

⁺ British Medical Journal 1952, II, 1011.

[‡] Information Digest 1953, I, 106.

[‡] British Medical Journal 1951, I, 1463.

Tuberculosis

Age Periods	<u>New Cases</u>						<u>Deaths</u>					
	Respiratory			Non Respiratory			Respiratory			Non Respiratory		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
0 -												
1 -												
5 -	1	1	2				1		1			
15 -	2	1	3									
25 -	1	3	4		1	1						
35 -	1		1				1		1			
45 -												
55 -	1	1	2				2		2			
65 and upwards												
Total	6	6	12		1	1	4		4			

Number of Cases on the Tuberculosis Register on 31st December, 1952.

(31st December 1951 in brackets)

	<u>Male</u>	<u>Female</u>	<u>Total</u>
Respiratory	52 (55)	21 (22)	73 (77)
Non-Respiratory	3 (3)	6 (4)	9 (7)
Total	55 (58)	27 (26)	82 (84)

During the year the number of cases on the Tuberculosis Register has decreased by 2, as shown in the second table. There were 13 new cases and 4 deaths as shown in the first table, and the balance is made up by a further 11 cases which were removed from the Register as under:-

Recovered	6
Dead	1
Left district	4
Not found in district after adequate search	0
Total	11

The Bulletin of the National Association for the Prevention of Tuberculosis, has been conducting a campaign in favour of B.C.G. (Bacille Calmette Guerin) vaccination against tuberculosis and I quote hereunder from relevant editorials. "Britain tends to occupy a somewhat isolated position in the world campaign against tuberculosis. We are not esteemed very highly as regards prevention. Reading the literature from other countries about the use of B.C.G., no one can fail to be struck by the contrast with our British outlook. Other nations, as for instance the countries of Scandinavia, place B.C.G. in the forefront of their preventive work. We in Britain appear to use it half heartedly. Another important question arises: it is still unlawful to manufacture B.C.G. in this country. This vaccine is being made in at least ten European countries, in Canada, the U.S.A., India, Ceylon, Australia, Singapore, Indonesia, Turkey, China, three South American countries, and in the U.S.S.R., but apparently it cannot be manufactured here. Seemingly the shoulders of our Government are not broad enough to bear this responsibility."* "The Ministry of Health speaks with two voices. One voice tells us we ought to have B.C.G. if we belong to one of three categories: the other tells us to wait until we can be sure whether it is desirable or not. Is this an attitude of scientific detachment, or is it merely an administrative compromise?"†

Dr. F.C.S. Bradbury's contribution on "Should School Leavers have B.C.G.?"‡ is of particular value and represents the most clearly thought out and logical expression of opinion on this matter that I have seen. "A good test of the value of any form of treatment, whether curative or preventive is "Would you apply it to your own family?" In the case of B.C.G. I unhesitatingly answer "Yes". It is discouraging to find among the present eligible groups, so relatively few who qualify for B.C.G. by being tuberculin-negative. Believing B.C.G. to be a valuable weapon in our anti-tuberculosis campaign, I would like to see it made available to a much wider population. The problem of segregation adds to our present difficulties but this would not arise with non-contact children. It is established that about 50 per cent of school leavers are tuberculin positive. This seems to me a strong reason for not specifying school leavers as a group to whom the availability of B.C.G. should be extended. Why not throw it open to all children, or if there must be a limit, why not choose the younger children? As I believe, from my own investigation that adult tuberculosis is a recrudescence of the primary lesion, I consider that every care should be taken of a child who is undergoing a primary infection. This will include measures to ensure that the child is prepared to deal with a primary infection and here B.C.G. occupies a high place. I would prefer to offer B.C.G. to the younger children. Apart from the medical aspect, the problem may become one of manpower and any large scale extension of B.C.G. to school children would no doubt require the co-operation of the School Medical Service."

Following the editorials in the October and December issues, the Bulletin has returned to the subject with further editorials in the February and April issues. "B.C.G. vaccine should be manufactured in Britain. B.C.G. should be available for use not only among the present categories, but more widely, at the discretion of physicians. The vaccination of school-leavers - that age group approaching the years of most serious liability to tuberculosis - should be added at once to the list of officially permitted categories."** "Scandinavian visitors and others smile and tell us that in Britain treatment is everything and prevention is nothing. There seems to be no immediate hope of B.C.G. being manufactured in this country. The extraordinary situation is to be allowed to persist that we depend upon supplies from outside. The Medical Research Council trials of B.C.G. and vole bacillus vaccine continue and one day we may expect definite results. We wish this zeal for research were matched by a corresponding energy in preventive medicine."†

Meanwhile, what does the Government say? Answering a question in the House of Commons, Commander T.D. Galbraith (Parliamentary Under-Secretary Scottish Office) says it would cost several thousand pounds to manufacture B.C.G. here. I suppose he forgets it costs more than several million pounds to deal with the manifold consequences of pulmonary tuberculosis.

*N.A.P.T. Bulletin 1952, 817.

†N.A.P.T. Bulletin 1952, 856.

‡N.A.P.T. Bulletin 1952, 857.

**N.A.P.T. Bulletin 1953, 2.

†N.A.P.T. Bulletin 1953, 37.

ENVIRONMENTAL HYGIENE

ANNUAL REPORT OF THE CHIEF SANITARY INSPECTOR

INSPECTIONS

The following table shows the number and nature of the inspections carried out during the year:-

Houses (H.A. 1936)	226
Houses (P.H.A. 1936)	455
Houses (Defence Regulations 68 A.A.)	30
Drains and Sanitary Fittings	293
Building Licensing	6
Water Supplies	35
Slaughterhouses	402
Knacker's Yard	28
Dairies	69
Pasteurising Plants	189
Ice Cream Premises	81
Food Premises	386
Unsound Food	93
Shops	39
Public Houses	1
Bakehouses	19
Factories	49
Workplaces	2
Public Conveniences	10
Public Conveniences at Inns	4
Watercress Beds	16
Swimming Pools	16
Moveable Dwellings	105
Piggeries	9
Market Stalls	36
Dustbins	1
Nuisances from:-	
Refuse	12
Smells	5
Animals	6
Smoke	13
Stables	1
Infested Premises:-	
Flies	8
Moths	1
Ants	1
Fleas	2
Cockroaches	15
Bugs	3
Rats and Mice	334
Filthy Premises	-
Infectious Diseases	13
Disinfections	26
Miscellaneous	1
TOTAL	<u>3041</u>

NOTICES SERVED

1. Informal Notices

Housing defects	31
Drains and Sanitary Fittings	20
Defective eaves gutters	14
Defective yard paving	2
Absence of water supply	1

2. Defects remedied after service of Informal Notices

Housing defects	20
Drains and Sanitary Fittings	16
Defective eaves gutters	-
Absence of Water Supply	-
Defective yard paving	2
	<hr/>
	38
	<hr/>

3. Statutory Notices

Housing defects	5
Drains and Sanitary Fittings	3
Defective eaves gutters	9
Nuisance from rubbish	1
Absence of Water Supply	1
	<hr/>
	19
	<hr/>

4. Statutory Notices complied with

Housing defects	4
Drains and Sanitary Fittings	2
Nuisance from rubbish	1
Absence of Water Supply	-
Defective eaves gutters	3
	<hr/>
	10
	<hr/>

HOUSING

Slum Clearance

Slum Clearance was restarted after a lapse of 12 years with the formation of a Slum Clearance Committee with powers and duties as an Executive Committee to make Demolition Orders under Section 11 and Section 12 of the Housing Act, 1936, and as an Advisory Committee to make recommendations to the Council on the subject of slum clearance and re-devolopment generally; to make recommendations as to assistance under Part II of the Housing Act, 1949; and to make recommendations regarding the improvement of existing houses and clearance and re-devolopment, under Parts II and III of the Housing Act, 1936.

This Committee called for a joint report on unfit houses by the Medical Officer of Health and the Chief Sanitary Inspector.

The Committee were unable to accept my suggestion that a housing survey should be carried out in the first place in order that an accurate report could be presented. This survey would have provided a mine of information and put the work on a proper footing from the start.

From information in the files and a preliminary survey, it was possible to present a rough picture of the position and some progress was made by the end of the year in dealing with properties already subject to Demolition Orders or Clearance Orders.

The Ministry of Housing and Local Government now call for a return and the form for the period ending 31st. December, 1952, is set out as follows:-

CLEARANCE AREAS AND INDIVIDUAL UNFIT HOUSES

Action taken under the Public Health and Housing Acts

Clearance Areas (Housing Act, 1936)			
	Number of Houses Demolished		Number of Persons Displaced
	Unfit Houses	Other Houses	
Land coloured "pink"	Nil	Nil	Nil
Land coloured "grey"	Nil	Nil	Nil

Houses not included in Clearance Areas		
	Number of Houses	Number of Persons Displaced
DEMOLITION & CLOSING ORDERS		
(1) <u>Housing Act, 1936.</u>		
(a) Houses demolished as a result of formal or informal procedure under Section 11	2	7
(b) Houses closed in pursuance of an undertaking given by the owners under Section 11, and still in force	3	4½
(c) Parts of building closed (Section 12)	1	2½
(2) <u>Housing Act, 1949.</u>		
(a) Closing Orders made under Section 3 (1)	-	-
(b) Demolition Orders determined and closing orders substituted under Section 3 (2)	-	-

REPAIRS	Number of * Houses
<u>Informal Action</u>	
(3) Number of unfit or defective houses rendered fit during the period as a result of informal action by the Local Authority under the Public Health Act or Housing Acts ...	22
<u>Action under Statutory Powers</u>	
(4) <u>Public Health Act</u>	
Number of houses in which defects were remedied after service of formal notices	
(a) by owners	7
(b) by local authority in default of owners ...	-
(5) <u>Housing Act, 1936</u>	
Number of houses made fit after service of formal notices (Sections 9, 10 & 16)	
(a) by owners	4
(b) by local authority in default of owners ...	-

* A defective house remedied more than once during the year is included once only.

Defence Regulations 68 A.A.

This Regulation, which provided for the licensing of houses, which were subject to Demolition or Clearance Orders, as a temporary measure for housing purposes, was revoked by Statutory Instrument 1952. No. 2091, except in relation to houses in respect of which licences were in force at the date of coming into operation of the Order viz. December 7th, 1952.

The effect of the Statutory Instrument is therefore, to permit the continued licensing of those houses already licensed before the 7th December, 1952 but to prevent fresh houses from being licensed.

Licences expiring on the 31st. December, 1952 were granted in respect of the following houses:-

(i) Clearance Areas

London Street Clearance Area No. 1. (7 houses)

4 houses - Nos. 73, 75, 77 & 79 London Street.

Licences in respect of other three houses revoked.

Winchester Street Clearance Area No. 1. (4 houses)

3 houses - Nos. 49, 51 & 53, Winchester Street.

Licences in respect of other house revoked.

(ii) Individual Demolition Orders and houses in respect of which Undertakings were given not to use for human habitation.

Block of 4 houses - Nos. 1 - 4, Fouthrops Yard.

2 houses Nos. 1 & 2, Fouthrops Yard.

Licences in respect of other two houses revoked.

The Council decided that no further licences would be issued in respect of any of the above houses and recommended that the occupants be rehoused as soon as suitable houses become available.

OVERCROWDING AND ALLOCATION OF COUNCIL HOUSES

Overcrowding due to the acute housing shortage is still serious. 3 reports on bad housing conditions were submitted to the Housing Officer in support of applications for Council houses. Co-operation exists between my department and the Housing Department, and the Housing Officer, Mr. R. B. Gillett, has kindly supplied the following figures:-

The number of names on the housing application list is as follows:-

Householders	89
Living and working out of Andover - (No previous residence in Borough)	21
Applications received less than twelve months ago	- 144
Aged persons applications	- 37
	<hr/>
	291

Applicants on current list:

No children -	95	
With children -	86	- 181
		<hr/>
Total		472
		<hr/>

COMPLAINTS

Further complaints were received from residents in the Foxcotte Road area of Charlton in respect of the alleged nuisance from the tipping of refuse and the burning of sawdust.

As previously reported, the Andover Borough Development Sub-Committee dealt with this matter at their meeting in June, 1951, and made the following recommendation:-

"That the Area Planning Committee make an Order under Section 26 of the Town and Country Planning Act, 1947, requesting the cessation of the use of the land at the Foxcotte Road Gravel Pits for the tipping of rubbish".

This Order was subsequently made by the Area Planning Committee and confirmation by the Minister is awaited.

Nuisances from grit and ash discharged from the stacks of boilers on three premises within the town area were in the course of being investigated at the end of the year and it seems that at least one will be converted to oil fuel in the near future.

The following is a list of the complaints received during the year and gives a good idea of the variety and amount of work involved:-

Housing Defects	...	...	...	...	...	...	...	19
Unsound Food	...	...	...	...	...	...	...	8
Smell Nuisance	...	...	...	...	...	...	...	9
Blocked drains and Sewers	...	...	...	...	...	...	...	69
Blocked Waterclosets	...	...	...	...	...	...	...	10
Defective Drains and Sanitary Appliances	...	...	...	...	...	...	...	5
Smoke Nuisances	...	...	...	...	...	...	...	2
Ants	...	...	...	...	...	...	...	5
Bugs	...	...	...	...	...	...	...	1
Fleas	...	...	...	...	...	...	...	3
Flies	...	...	...	...	...	...	...	2
Dirty Milk	...	...	...	...	...	...	...	3
Unauthorised Erections	...	...	...	...	...	...	...	2
Nuisance from Animals	...	...	...	...	...	...	...	1
Condition of Moveable Dwellings	...	...	...	...	...	...	...	1
Filthy Premises	...	...	...	...	...	...	...	1
Dead Cat in Swill Bin	...	...	...	...	...	...	...	1
Nuisance from Swill Bin	...	...	...	...	...	...	...	1
Absence of Dustbin	...	...	...	...	...	...	...	1
Illegal Camping	...	...	...	...	...	...	...	1
Broken Fence	...	...	...	...	...	...	...	1
Wasps Nest	...	...	...	...	...	...	...	1
Nuisance from Pigeons	...	...	...	...	...	...	...	1
Tipping of Refuse	...	...	...	...	...	...	...	1
Overhanging Hedgerow	...	...	...	...	...	...	...	1
TOTAL								<u>150</u>

SANITATION

It will be seen from the General Statistics that there are 4047 inhabited properties within the Borough. A total of 354 houses are not connected to the main sewerage system and of these 157 are provided with drainage to a cesspool or septic tank, 173 have pail closets and 14 chemical closets.

The increase on the 1951 figures in the number of properties connected to a cesspool or septic tank is accounted for by the erection of six new houses and the conversion of 1 pail closet to a water closet in unsewered parts of the Borough.

Two bucket closets were eliminated when the dwellings were demolished. Fifteen properties in the Town Area with pail closets, 12 of which have waste water drainage to the sewer, remain to be dealt with and it will be difficult to eliminate these unless the Council are prepared to carry out the work under the provision of Section 47 of the Public Health Act, 1936 and bear half the expense.

The clearing of blocked drains and waterclosets is treated as a public health service and 75 of these were cleared forthwith by my department without charge. Repairs and improvements to drains and sanitary fittings were effected at 18 premises and 54 hydraulic and smoke tests were applied in connection with this work.

There is still urgent need for modern public sanitary conveniences in the Town and for the improvement of existing arrangements by the provision of proper washing facilities with hot water to meet present day requirements. This also applies to the public Parks and Cricket ground.

The extension of the sewer at Charlton village is still an urgent matter and should receive further consideration by the Highways and Works Committee.

DISINFECTION AND DISINFESTATION

The Borough is without a steam disinfecter and articles requiring steam disinfection are dealt with at the Victoria Isolation Hospital, Winchester at an agreed charge.

Disinfection of thirteen premises was carried out after infectious diseases.

Disinfestation work was carried out at three premises found to be infested with bugs and at two houses found to be infested with fleas, a liquid insecticide being used in each case.

Fifteen houses and a bakehouse infested with cockroaches were treated with Gammaxene powder applied by means of a blower.

Nuisance from ants entering houses was dealt with on one occasion by the use of liquid and powder insecticide.

Eight complaints of nuisance from house flies were dealt with during the season, advice being given and spraying carried out where necessary, and one wasps nest was destroyed at the request of a householder.

An unusual infestation was found at the end of May when a complaint was received that numerous caterpillars had invaded a house in the village of Charlton.

The caterpillars were found to be those of a species of Small Ermine Moth (*Hyponomeutidae Cognatella*) which feeds on the Evergreen Euonymous (*Euonymous japonica*).

Several of the species of Ermine moths are common in gardens and sometimes occur in great abundance, their larvae causing damage to fruit trees and shrubs. The caterpillars are gregarious and live in webs. They pupate in June in the web or in rubbish on the ground and the moths emerge in July and August. The moths have white or grey fore wings with numerous small black dots.

As far as is known the caterpillars are harmless except for the damage they cause to the plant on which they are feeding.

The whole of the evergreen and the front of the house were festooned with the webs.

A combination of circumstances favourable to pupation was responsible for this infestation, the Euonymous being trained up the front of the house which faced south and a prolonged spell of really hot weather in May produced so many caterpillars that natural biological control failed to reduce their numbers.

Usually, so many are eaten by birds or killed by parasites that it is not necessary to take special precautions. A water miscible D.D.T. was found to be effective in this case.

MOVEABLE DWELLINGS

(a) Sites for Moveable Dwellings

A licensed site for two caravans at the Acre Iron Works continued in use as such until November of this year when the dwellings were removed.

A licensed site at Harewood Garages, London Road, permitting six tents or mobile caravans to be stationed thereon continued to be satisfactorily maintained during the year.

The decision of the Minister in the appeal, held in November, 1951, against the refusal by the Planning Authority to grant a development application in respect of a site at Shepherd's Spring, was received in March.

The Minister had considered all the facts and representations and agreed that the main objection to the proposal was the possible effect on the town's water supply and had consequently dismissed the Appeal.

(b) Camping on Unlicensed Sites

Camping on the two sites west of New Street dealt with in my report for the year 1951, still continued. Proceedings will be taken against the owners of the land and the occupiers of the shacks as soon as the Municipal Site is ready for use.

(c) Municipal Camping Site

The Council decided to proceed to make a compulsory purchase order under the provisions of the Acquisition of Land (Authorisation Procedure) Act, 1946, and Section 38 of the Town and Country Planning Act, 1947, in respect of a parcel of land at Pickett Twenty.

An Inquiry into the use of the land was held on the 22nd April, by the Minister of Housing and Local Government and the Order was subsequently confirmed, enabling the Council to compulsorily acquire the land for the purposes of a Municipal Camping Site.

Application for permission to raise a loan with the Public Works Loan Board for the purpose, also to carry out works of development and to the leasing of individual caravan sites, was eventually granted.

Detailed conditions regulating the use of the site were being prepared at the end of the year.

(d) Moveable Dwellings

Applications for individual licences were granted in respect of fourteen dwellings for a period of twelve months, six for a period of six months, one for a period of four months and one for a period of three months. Two applications for licences were refused but one was subsequently granted.

WATER SUPPLIES

Public Supply

The Public Supply is derived from the borehole at the Council's Smanell Road Waterworks, and pumped to a covered reservoir of 500,000 gallons capacity at Bere Hill. The supply is continuous and no shortage has been experienced during the year.

The Borough Surveyor, who is the Council's Water Engineer, submits regular monthly samples to the Public Health Laboratory, Winchester, for bacteriological examination. These samples are taken from the borehole, the reservoir and from various points on the system and very satisfactory reports have been received in each case. The supply is chemically treated by chloramine process and frequent chlorine residual tests are made.

There were no main extensions other than required for new housing sites in or near the Town Area.

Private Water Supplies

A total of 133 dwelling houses are not connected to the Public Supply, but receive supplies as follows:-

(a) Private Piped Supplies

1. Burfoot and Loveridge, Woodhouse.

Supplying 2 houses (also provides a supply to a bakehouse at Woodhouse)

2. W. A. Motley, Harewood Farm, Andover Down.

Supplying 18 houses (also provides a supply to a garage with a camping site, a turkey farm and one dairy farm at Andover Down)

(b) Shallow Wells and Bores

A total of 113 dwelling houses within the Borough derive a supply of water for domestic purposes from shallow wells and bores, the water being raised by means of bucket and windlass in most cases, and by hand pumping in the remainder. The structure of dug wells is generally of a low standard and in some cases dangerous.

One house, 8, Pickett Twenty, taking water from a shallow well some distance away was connected to the main supply as the result of the service of a Statutory Notice under the provision of Section 138 of the Public Health Act, 1936, the Council carrying out the work in default.

The well supplying water to Nos. 6, 7, 8 & 9, Pitt Cottages, Woodhouse, was found to be polluted in 1951; a supply of water for domestic purposes is provided by the Council by means of a mobile tank as a temporary measure until the main is extended to this area.

21 samples of water were taken as the result of complaints or routine investigation and submitted for bacteriological examination. Seven of these samples were reported upon as unsatisfactory and action was taken as follows:-

- | | |
|---|---|
| 3 samples from a deep well supplying a mill and canteen | - Well supply discontinued, connected to main supply. |
| 2 samples from a shallow well at Pickett Twenty | - Intermittent pollution mainly due to bad structure of well. Defective drains found and repaired. Negotiations in progress to extend main supply to this area. |
| 1 sample from shallow well at Pickett Piece | - Unsatisfactory well. Informal action taken at end of year to secure improvement. |
| 1 sample from shallow well at Woodhouse | - Water for domestic purposes now taken from bore at adjoining premises, as a temporary measure until main supply is extended. |

(c) Supplies to Dairies and Dairy Farms

The duty of ensuring that dairy farm premises are provided with a supply of water suitable for the requirements of the Milk and Dairies Regulations, 1949, passed to the Ministry of Agriculture and Fisheries on October 1st, 1949, but I am not aware that any regular sampling is carried out as was the practice under local authority control.

One dairy pasteurising milk derives its water supply from a bore on the premises and quarterly samples taken and submitted for bacteriological examination proved very satisfactory.

SWIMMING POOLS AND HOT BATHS

Borough Swimming Pool

The Borough Swimming Pool, opened in 1937 and situated in the Walled Meadow, is 75 feet by 30 feet wide. The depth varies from 3 feet at the shallow end to 8 feet at the deeper. The pool is in charge of a fully qualified superintendent and his wife, Mr. and Mrs. Hughes. Mrs. Hughes is a fully qualified nurse and is in constant attendance during the season. Two attendants are also employed and hygienic conditions are well maintained, in spite of the unsatisfactory turfed surroundings.

Special attention is given to the purity of the water which is continually circulating at the rate of 13,800 gallons per hour, filtered and chlorinated. Chlorine residual tests are carried out daily and regular samples taken by my department during the swimming season all proved satisfactory. Reports on all samples are posted on the notice board at the pool and are noted with interest by the public.

A hot bath service is maintained throughout the year in the buildings attached to the pool. Very great credit is due to the Superintendent and his wife for the very excellent manner in which the pool is managed and I am indebted to them for supplying the following statistics for the year:-

Bathers	-	25,318
Spectators	-	3,278
Hot Bath Patrons	-	1,274
		<hr/>
TOTAL		29,870
		<hr/>

Andover Grammar School Pool

This pool, used by scholars and "Old Hansonians" is under the control of the County Education Authority and has a capacity of 63,000 gallons. The water supplied from the mains is changed every three or four weeks according to weather conditions and use of the pool. The underwater surfaces are cleaned by special cleaning equipment to prevent growth of algae.

The water is chlorinated by hand dosing according to the use of the pool. The County Education Authority have not yet taken steps to ensure that a proper filtration and chlorination plant is installed comparable with the Municipal Installation. Regular samples are taken by my department during the swimming season and one proved to be slightly contaminated.

Private Swimming Pools

There are three pools in use within the Borough constructed in the grounds of private dwelling houses and used solely by the occupants and their friends.

These pools are filled from the public mains and chlorination is by hand dosing.

WATERCRESS BEDS

Watercress growing is classified as one of the industries of Andover and a fair number of persons of both sexes find regular and seasonal employment in its various branches.

The groups of beds in the Borough of Andover cover an area of approximately 12 acres and the produce finds its way to most of the large markets by rail and road.

Regular inspections of watercress beds are made to ensure that they are properly protected from pollution and samples of water taken and submitted for bacteriological examination. The standard of purity of the water aimed at is not less than that of drinking water.

Eleven samples of water and three samples of watercress taken and submitted for bacteriological examination were reported upon as being satisfactory. One sample of river water used to supplement the supply to a nursery bed showed that the river was not heavily contaminated at that point.

GAME DEALER'S LICENCES

My department is responsible for the issue of these licences and fourteen were in force at the end of the year as follows:-

Messrs. A. Marchmont & Sons, Charlton.
A. C. Stevens, Bridge Street.
Messrs. Carruthers & Co. Ltd., Bridge Street.
Messrs. H. W. Burden & Son, High Street.
Messrs. Clark Bros. Ltd., Bridge Street.
Messrs. Stevens Bros., Charlton.
Messrs. F. T. Burden & Son, Millway Road.
Andover Co-Operative Society Ltd., Bridge Street.
Webb & Wilson (Andover Co-Operative Society Ltd.)
Messrs. Lovell's Dairy, 47, High Street.
W. T. Stevens, "Fourways", London Road.
T. W. Smith, 11, London Street.
Messrs. Noyce Bros., Winchester Street.
Messrs. Howard & Son, High Street.

PET ANIMALS ACT, 1951

The above Act came into force on the 1st. April, 1952 and provides for the licensing of persons keeping pet shops subject to compliance with such conditions as may be specified in the licence.

The Council appointed the Chief Sanitary Inspector as the Authorised Officer to enter and inspect at all reasonable times any licensed premises and any animals found thereon, with power to consult a Veterinary Officer where necessary.

One licence only has been issued in respect of a shop selling goldfish.

RAG FLOCK AND OTHER FILLING MATERIALS ACT, 1951

Under this Act, which became operative on the 1st. November, 1951, certain premises wherein any of the filling materials prescribed in the Act are used for upholstery, stuffing or lining of bedding, toys, baby carriages, etc. have to be registered with the Council.

The only premises required to be registered are those used by Enham Industries, Enham-Alamein and these were inspected twice during the year.

MILK SUPPLY

There are nine persons registered as distributors of milk and eight premises registered as dairies within the Borough.

The County Council delegated its powers in respect of the licensing and supervision of pasteurising plants to the Borough Council and licences issued under the Milk (Special Designation)(Pasteurised and Sterilised Milk) Regulations, 1949, are as follows:-

Dealers (Pasteurisers) Licences - 4
Dealers Pasteurised Milk Licences - 3

Licences issued under the Milk (Special Designation)(Raw Milk) Regulations, 1949, are as follows:-

Dealers Tuberculin Tested Licences - 4

Supplementary Licences to use the special designations "Pasteurised", "Sterilised" and "Tuberculin Tested" were granted to an Eastleigh firm distributing milk to the Andover War Memorial Hospital.

Pasteurising Plants

There are four milk pasteurising plants in operation within the Borough, one plant coming into operation during the year. There are two plants of the Holder Type and two High Temperature Short Time installations.

The water supply for one plant is obtained from a borehole on the premises and quarterly samples submitted to the Public Health Laboratory were all reported upon as being satisfactory except one which proved to be slightly contaminated.

MILK SAMPLING

Tuberculin Tested Milk

Six samples of bottled Tuberculin Tested milk were taken for bacteriological examination during the year and all satisfied the official test.

Pasteurised Milk

A total of one hundred and eighty-three samples were taken from plants during the year all of which satisfied both the Phosphatase and Methylene Blue tests except three samples which failed the Phosphatase test.

Ungraded Milk

A bacteriological standard for Ungraded milk does not exist but samples are taken for the Methylene Blue test as a check. Samples taken and subjected to the Guinea Pig Test for the presence of Tubercle Bacilli all gave a negative result.

Only a matter of a few pints a day are sold at the present time, practically all milk distributed within the Borough being Pasteurised or Tuberculin Tested.

MILK BOTTLE CLEANSING

Two hundred and seventy-eight bottles were taken during the year for bacteriological examination, two hundred and fourteen of which proved satisfactory, thirty-eight fairly satisfactory and twenty-six unsatisfactory. In the case of unsatisfactory results the method of cleansing is checked and advice given.

No official bacteriological standard exists for milk containers but the provisional classification suggested by the Director of the Public Health Laboratory at Winchester is recognised.

The provisional classification for milk bottles is as follows:-

Mean Bottle Count, reckoned as per pint bottle.

Not more than 600	Satisfactory.
Over 600 but less than 2,000	- Fairly satisfactory.
Over 2,000	- Unsatisfactory.

I make no apology for repeating the following statement made in my report for 1951. Although it is the responsibility of the dairyman to properly cleanse milk containers, it is regrettable to note the condition of milk bottles returned to dairies by the public. Very few are given a rinse under the tap when emptied and very many have been used as containers for substances other than milk.

People tend to accumulate milk bottles in which case the small quantity of milk, if left in the bottle, and not rinsed out, dries on the glass and often the modern bottle washing machine will not remove this film without pre-soaking and brushing. This increases the task of the dairyman and costs money and often results in complaints from the public who by their very actions in this respect create the trouble.

The schools are not entirely without blame in this respect and all children should be taught to rinse their bottles after drinking the milk and in this way the seed would be sown for carrying on the good work in the home.

Alleged contravention of the Milk and Dairies Regulations, 1949.

Dirty Milk Bottle

An Andover milk firm was summoned for failing to ensure that a milk bottle, containing milk, was in a state of thorough cleanliness as required by the provisions of Regulation 26.

A housewife brought a bottle of milk to the Chief Sanitary Inspector's Department and complained that it was dirty.

A dirty brown mark was visible down one side of the bottle and when shaken some of this dirt dissolved into the milk.

The firm had previously been warned when milk bottles submitted for bacteriological examination were found to be unsatisfactory.

The defendants pleaded guilty and a fine of £10 was imposed.

MANUFACTURE AND SALE OF ICE CREAM

The manufacture, storage and sale of ice cream is controlled by the Registration of premises under Section 14 of the Food and Drugs Act, 1938, and also by the provisions of the Ice cream (Heat Treatment etc.) Regulations, 1947, and deals with heat treatment, cooling and storage and the protection of the ice cream from contamination.

Three premises within the Borough are registered under the Food and Drugs Act, 1938, for the manufacture of ice cream.

Thirty-one premises are registered for the storage and sale of ice cream and in addition to the ice cream manufactured within the Borough, the product of no fewer than ten factories situated outside the Borough is sold on these premises. Ice cream is also being sold at most restaurants, cinemas and canteens, which premises do not require to be registered under the provisions of the Act.

Frequent inspections are made of all premises, whether registered or not, in order to ascertain that hygienic conditions are maintained and the legal requirements as to temperature are observed.

Notices reminding persons to keep their hands clean and particularly to always wash their hands after using the sanitary conveniences, are posted in suitable positions on all premises.

There is no legal standard laid down as respects the bacteriological purity of ice cream but a form of Methylene Blue reduction test is adapted for testing and used as a basis for defining four grades of bacteriological cleanliness. It is suggested that if, out of the four grades recommended, ice cream consistently fails to reach grades one and two, it would be reasonable to regard this as indicating defects of manufacture, or of handling which call for further investigation.

Seventy-three samples of ice cream were submitted for bacteriological examination by the Methylene Blue reduction test at the Public Health Laboratory, Winchester, with the result that,

- 60 samples were placed in Provisional Grade 1.
- 9 samples were placed in Provisional Grade 2.
- 4 samples were placed in Provisional Grade 3.
- 0 samples were placed in Provisional Grade 4.

It can be said that the test still proves to be very useful and improvements have resulted from advisory work on premises where samples have failed to reach Grade 1 and 2.

MEAT AND FOOD INSPECTION

Slaughtering

Slaughtering continued to be carried out at the Andover Co-Operative Society slaughterhouse, Southend Road, which is requisitioned by the Ministry of Food for the purpose of slaughtering animals for human consumption to serve the needs of the Borough and parts of the Andover, Whitchurch and Kingsclere Rural Districts. Cattle for the Borough of Basingstoke are also slaughtered on these premises.

The officials of the Ministry of Food and the Slaughtering Contractor and Staff continued to co-operate fully with my department which is responsible for carrying out the duties of Meat Inspection and I again wish to record my appreciation of this co-operation.

Hygiene in Slaughterhouses

It is satisfactory to note that hygienic practices in connection with the slaughter and dressing of carcasses is steadily improving, due mainly to the attendance of a Meat Inspector during most of the time when slaughtering is being carried out.

The Report of the Interdepartmental Committee on Meat Inspection was received in 1951 and as a result of the recommendations made, a revised Memorandum (Memo. 3/Meat) on Meat Inspection was issued by the Ministry of Food in December with the suggestion that this Memorandum be adopted in substitution for Memo. 62/Foods on the 1st. February, 1953.

The Memo. will be studied and a report submitted to the Council and this matter will be dealt with in my Report for 1953.

The need for simple and hygienic equipment and means of knife sterilisation had long been felt and this was further stressed in the Report of the Departmental Committee on Meat Inspection and now Memo 3/Meat Part 1, provides that tools, implements and equipment should be kept clean, that meat inspectors and slaughtermen should have a sufficient number of knives to allow for replacement of a contaminated knife at any time.

Knives and other equipment which have been in contact with a lesion of disease should be cleaned and sterilised before again being used, and always at the end of each working day.

The Andover system serves the purpose and provides:-

1. Protective Clothing

Consisting of rubber boots, long white coat, white plastic apron and washable cap.

The advantage of the plastic apron is that it can be continually washed down whilst being worn and protects the white coat from gross contamination. The cap is not always worn, but is necessary for carcase work.

2. Hygienic all-metal Knife Scabbard

This is made of a light alloy attached to a leather belt and takes up to 4 knives. It has a detachable front to allow for easy cleaning and sterilisation.

3. Knife Sterilisation Unit

The steriliser is constructed of heavy gauge aluminium alloy, being 9" in depth, 9" long and 6" wide. The close fitting lid is slotted down the centre and fitted with an adjustable cover strip and will take up to 6 knives at a time. Heating is by an immersion element which automatically throws out the plug should overheating take place.

OPERATION

The steriliser is filled with cold water containing a few crystals of sodium hexa-metaphosphate (Calgon). The use of Calgon prevents the formation of scale and makes a more effective sterilising solution. Brought to the boil at the beginning of operations, the steriliser need only be switched on for 5 minutes or so when it will steam for more than 10 minutes, thus sterilised knives are always available for use. A contaminated knife is washed in a seamless, dairy type bucket containing a solution of hot dettol and soda water, then placed in the steriliser and steamed for at least 10 minutes. Steam escaping through the sloop passes over the handles of the knives. Should complete sterilisation be required, the knives can be completely immersed in the sterilising solution.

GENERAL

The all metal scabbards are easily cleaned in the dairy type bucket containing hot dettol-soda solution preventing contamination of the sterilised knives.

In practice the system has had a good effect on the slaughtermen. The contractor has obtained metal scabbards for their use and he is now interested in knife sterilisation.

The system is recognised by the Area Technical Advisor on Meat Inspection and the Public Health Laboratory as providing a simple and reasonably efficient means of meeting with the requirements of Memo 3/Meat.

Inspection

100% inspection of all animals slaughtered was carried out and this entailed 402 visits and working a great number of hours beyond normal during the year, apart from Sunday slaughtering during the peak periods.

A total of 7,820 animals were slaughtered during the year and a total of 25 Tons. 2 cwts. 32 $\frac{1}{2}$ lbs. of meat and organs were condemned as unfit for human consumption.

The following tables give details of the carcases inspected and condemned and the weight of meat and organs condemned.-

Carcases Inspected and Condemned

	Cattle excluding Cows	Cows	Calves	Sheep and Lambs	Pigs
Number killed	2066	733	830	3378	813
Number inspected	2066	733	830	3378	813
All diseases except Tuberculosis Whole carcasses condemned	1	9	6	13	27
Carcasses of which some part or organ was condemned	887	380	24	694	287
Percentage of the number inspected affected with diseases other than T.B.	42.9%	53.0%	3.6%	20.9%	38.6%
Tuberculosis only Whole carcasses condemned	5	16	1	2	6
Carcasses of which some part or organ was condemned	153	156	0	0	31
Percentage of the number inspected affected with Tuberculosis	7.6%	23.4%	.12%	.05%	4.5%

Weight of Meat and Organs Condemned

	Tuberculosis cwts. qrs. lbs.			Other diseases cwts. qrs. lbs.		
Carcasses and parts of carcasses	120	3	15	103	-	19
Organs	84	1	15	193	3	11½
TOTALS	205	1	2	297	0	2½
Total weight:- 25 Tons. 2 cwts. 32½ lbs.						

Meat and Offal Condemned on Butchers' Premises

One thousand nine hundred and ninety-six pounds of Home Killed Meat was condemned as unfit for human consumption on butchers' premises by reason of bone taint.

Corned Beef

Twenty-four pounds of imported canned beef was condemned as unfit for human consumption on butchers' premises and at the Ministry of Food Distribution centre.

Disposal of Condemned Meat

The disposal of condemned home killed meat, imported meat and Corned Beef is dealt with by the Ministry of Food. Meat and offal is coloured with a vegetable dye and regularly collected by contractors and removed for proper treatment in steam digestors or concentrating plants.

CYSTICERCUS BOVIS

100% inspection of beef carcasses and offal for the detection of lesions is carried out and twenty-one cases were discovered during the year.

Cysticercus Bovis is the cystic stage of the tapeworm Taenia Saginata in man and was considered rare in this country until reports of cases were received during 1948.

Affected carcasses and offal are removed to Reading for cold storage for a period of 21 days at a temperature not exceeding 20°F. after which the meat is released for manufacturing purposes.

The following table gives details of the animals affected which shows a reduction on the figures for 1951:-

<u>Class of Animals</u>			
<u>Steers</u>	<u>Heifers</u>	<u>Cows</u>	<u>TOTAL</u>
9	7	5	21
<u>Percentage of the total number of animals slaughtered in each class.</u>			
<u>Steers</u>	<u>Heifers</u>	<u>Cows</u>	
.91%	.61%	.73%	
<u>Percentage of the total number of all animals slaughtered</u>			
	.74%		
	1.4 % (1951)		

Foot and Mouth Disease

The slaughterhouse was declared an infected place after the discovery of lesions in a calf during the course of meat inspection on Sunday, 5th October, 1952.

This was notified to the Ministry of Agriculture and Fisheries and confirmed and the slaughterhouse was placed under special restrictions. It was found that this calf came from one of two farms in the Rural District at Grately and Quarley where cattle were affected and the usual movement restrictions were placed on the area embracing the Borough of Andover.

Swine Fever

Swine fever was diagnosed in three pigs during the course of meat inspection on Sunday, 27th April, and notified to the Ministry of Agriculture and Fisheries as a result the outbreak was quickly controlled.

The slaughterhouse was declared an infected place and closed for a week.

REPORTS TO OTHER AUTHORITIES

All cases of generalised tuberculosis in cattle, congenital tuberculosis in calves and cystic infestation in all classes of animals, is reported to the Medical Officer and Divisional Veterinary Officer of the County concerned. Twenty-one cases of generalised tuberculosis were reported during the year. Twenty-one cases of *Cysticercus Bovis* and two cases of congenital tuberculosis in calves were notified during the year. It is hoped that the Veterinary profession will in future make more use of the valuable information available at the slaughterhouse regarding the diseases of animals. The continued loss of liver by reason of fluke (*Distoma Hepaticum*) is still a matter for attention, 1064 livers being condemned during the year 1952, the percentage of offal being 28.9% in cattle and 7.4% in sheep.

Other Foods Condemned

Condemnation certificates were issued in respect of the following food voluntarily surrendered by private traders:-

Weight in lbs.

Sliced bacon	-	3½ lbs.
Reindeer Meat	-	14 lbs.
Cooked ham	-	166 lbs.
Frozen Red Currants	-	14 lbs.
Total weight:		197½ lbs.

<u>Canned Food</u>	<u>Cans</u>
Meat	- 160
Milk	- 36
Soup	- 2
Beans	- 3
Fruit	- 536
Peas	- 43
Fish	- 28
Vegetables	- 4
Mincemeat	- 1
Jam	- 2
Sausages	- 5
Coffee	- 1
Salmon	- 1

Total Number of cans:- 852

Sundry other foodstuffs were condemned including 28 packets of spaghetti, 18 packets of desicated coconut, 14 jellies and 106 packets of cheese.

The disposal of this food is dealt with by the Borough Council.

Proceedings under Section 9 of the Food and Drugs Act, 1938.

Cockroach in Bread

Proceedings were instituted against a shopkeeper for selling a loaf of bread unfit for human consumption. After purchasing the loaf, the person took it home and after cutting about four slices for his lunch, came across a cockroach embedded in the centre of the loaf which he took to the Sanitary Inspector's office. The bread was supplied to the shopkeeper from a bakery at Abbott's Ann in the Rural District.

The shopkeeper took advantage of the defence available under Section 83, which entitled him to bring the manufacturer of the bread before the Court. The defence submitted that the existance of a cockroach in the bread would not render it unfit for human consumption.

The Magistrates dismissed the case against the shopkeeper and found the case proved against the manufacturer as in their opinion the loaf was unfit for human consumption, and imposed a fine of £2. The Chairman said that the Council summoned the wrong person and awarded the shopkeeper £3. 3s. Od. costs against them.

Proceedings in Respect of Alleged Contravention of the Clean Food Byelaws.

Proceedings were taken against the Manager of a Tidworth firm of bakers and confectioners alleging contraventions of Clauses 2 and 4(d) also against the owner of a cake shop in Andover taking delivery of cakes from this firm for alleged contraventions of Clauses 4(a) and 4(d)

The vehicle used by the bakery firm to deliver cakes was found to be in a filthy condition and trays containing cakes were also found to be dirty. The Manager, who drove the vehicle and delivered the cakes, wore filthy clothing and his hands were filthy.

Cakes were placed on the counter of the shop in trays in the same condition as delivered and without any protection from contamination by customers.

The Manager of the bakery was fined £2 for failing to keep his vehicle clean and £2 in respect of the dirty trays, but the third summons regarding personal cleanliness was dismissed.

The shopkeeper was fined £1 for failing to take steps to protect the cakes from contamination by contact with the dirty trays but the second summons in respect of failure to protect the cakes from contamination by other persons was dismissed.

The Solicitor for the defence, Mr. Mathers, Swindon, said that he thought the Byelaws were, in practice, unreasonable. It was impossible to carry out the high standard demanded by them, he maintained.

THE PREPARATION OR MANUFACTURE OF SAUSAGES OR POTTED, PRESSED, PICKLED OR PRESERVED FOOD.

Control of premises used for the above purposes is by Registration under Section 14 of the Food and Drugs Act, 1938, and also Parts V and VI of the Public Health (Meat) Regulations, 1924 and the Clean Food Byelaws.

A total of 19 premises in the Borough are Registered under the Act, including 12 for the manufacture of sausages, two for the manufacture of pies, four for fish frying and one for the manufacture of pickles.

Frequent visits are made to these premises and improvements continue to be carried out at premises as the result of advice given.

Notices reminding persons to keep their hands clean and particularly to always wash their hands after using a sanitary convenience, are posted in suitable positions on all premises.

MARKET STALLS AND STREET FOOD TRADERS

The Saturday open air Market continues but fortunately, not many food traders other than greengrocers and fruiterers, have re-established themselves. The fish stall is being renewed to meet with modern requirements. Some difficulty was experienced with a sweet stall holder who eventually ceased business.

The number of stall-holders selling foodstuffs in the market is as follows:-

Fruit and greengrocery	-	6
Fish	-	1
Canned and Pre-packed goods	-	1

Control of this market particularly from the litter angle and the dumping of produce on the highway has improved since Regulations were made by the Council and a Market Superintendent appointed.

A wash basin installed in the Guildhall conveniences for men, which can be used by street traders, is of little value, there being no hot water, soap or towels available. The Council should set a high standard in this respect.

The number of Street Traders, other than stallholders, is as follows:-

Fruit and Greengrocery	- 4
Fish	- 2
Ice cream	- 1

The Council have adopted Byelaws with respect to the handling, wrapping, etc. of food, and the sale of food in the open air and these are of great assistance in maintaining hygienic conditions.

CLEAN FOOD CAMPAIGN

No special campaign has been undertaken, but a survey of all food establishments was commenced in October, 1951, and Mr. Crow, my assistant, who is particularly qualified for this work, is still actively engaged on inspections and advisory work.

I am still of the opinion that proper and frequent inspections of food premises and a direct approach to the food handler is the real answer to the problems. The adoption of Byelaws has helped considerably in the campaign to improve hygienic conditions in the food trades, but some difficulty is still encountered in Andover where the sale of foodstuffs in an open market is permitted and encouraged because of the revenue from stall fees.

THE SLAUGHTER OF ANIMALS ACT, 1933

The above Act provides for the humane and scientific slaughter of animals, the licensing of slaughtermen and for purposes connected therewith. My Department is responsible for the enforcement of the Act, and the slaughtermen's licences are granted by the Council only after receiving a satisfactory report from those officers who are able to observe the slaughtering of animals whilst engaged in meat inspection duties at the slaughterhouse and the inspection of Knacker's Yards.

17 applications for licences were granted for a period of 12 months in each case. Action regarding contravention of the provisions of the Act was not found necessary during the year but several warnings were given in respect of careless unloading of cattle delivered at the Slaughterhouse.

The Temple-Cox and Cash captive bolt type humane killer is used at the controlled slaughterhouse also a long arm Greener killer which fires a bullet is used on occasions for bulls and dangerous animals and I am pleased to report that every endeavour is made to ensure that all animals are slaughtered without pain or suffering and demonstrations of the methods employed will always be given to anyone interested.

The Council of Justice to Animals and Humane Slaughter Association have kindly provided a Cash Captive Bolt pistol which is made available for use by persons who obtain licences from the Ministry of Food to slaughter animals for their own consumption on private premises where the Slaughter of Animals Act does not apply.

KNACKER'S YARDS

The Knacker's Yard within the Borough situated at Andover Down continued to be licensed under the Food and Drugs Act, 1938, for periods of six months. These premises are also licensed by the Ministry of Food under the Knacker's Yard Order, 1948.

Byelaws made under Section 58 of the Food and Drugs Act, 1938, are in force within the Borough requiring the person licensed to keep and produce when required, records of animals brought into the yard and of the manner in which those animals, and the different parts thereof, were disposed of.

The colouring of meat with a vegetable dye before leaving the place of slaughter is enforced under the provisions of the Livestock (Restriction of Slaughtering)(No. 2.) Order, 1947 by the Ministry of Food.

There is practically no control over the handling of meat once it has left the Knacker's Yard, and raw meat from animals slaughtered by reason of all manner of diseases ultimately reached the home by way of the cat and dog meat shop, the danger of which is apparent and cannot be over-emphasised.

I repeat my statement made in previous yearly reports, that meat should not be permitted to leave the Knacker's Yard unless sterilised by heat treatment or dispatched in sealed containers to a place where treatment can be effectively carried out. Disposal in certain directions where the meat may be used for human consumption could be avoided in this way.

The Council received this part of the report with some concern and the Town Clerk was instructed by the Council to request the Association of Municipal Corporations to investigate the matter at an early opportunity.

A Memorandum was prepared for the use of the Council's representative on the Health Committee of the Association of Municipal Corporations.

The matter was subsequently considered by the Health Committee of the Association of Municipal Corporations and a Circular letter asking for observations was sent to all members in November with a view to the preparation of a report by the Secretary.

SHOPS

Shops Act, 1950.

This Act consolidates the Shops Acts, 1912 to 1938, and came into force on the 1st. October, 1950.

Routine inspections are carried out covering the following matters:-

- Provision of washing facilities and sanitary accommodation;
- Provision of lighting and heating;
- Facilities for taking meals;
- Closing of shops on weekly half-holidays;
- Evening closing;
- Assistants weekly half-holidays and meal intervals;
- Conditions of employment of young persons under 18 years of age;
- Sunday trading.

Proceedings in respect of alleged contraventions of the half-holiday closing provisions during the Xmas period will be dealt with in my report for 1953.

BUILDING LICENSING

The Chief Sanitary Inspector is the appointed Licensing Officer for building work to dwelling-houses other than work requiring plans to be deposited under the Building Byelaws.

Seven applications have been dealt with and licences issued to the value of £1,657. 3s. 9d.

INSPECTION OF FACTORIES

Factories Acts, 1937 and 1948

1. Inspections for purposes of provisions as to health

Premises	Number on Register	Number of		
		Inspections	Written Notices	Occupiers Prosecuted
(i) Factories in which Sections 1,2,3,4 and 6 are to be enforced by Local Authorities	14	14	1	-
(ii) Factories not included in (i) in which Section 7 is enforced by the Local Authority	74	35	1	-
(iii) Other premises in which Section 7 is enforced by the Local Authority (excluding outworkers' premises)	3	-	-	-
TOTAL	91	49	2	-

2. Cases in which defects were found.

Particulars	Number of cases in which defects were found				Number of cases in which prosecutions were instituted
	Found	Remedied	By H.M. Inspector	Referred By H.M. Inspector	
Want of cleanliness	1	1	Nil	Nil	Nil
Unreasonable temperature	-	-	-	-	-
Sanitary Conveniences					
(a) In-sufficient	-	-	-	-	-
(b) Un-suitable or defective	1	1	-	-	-
(c) Not separate for Sexes	-	-	-	-	-
Other offences	-	-	-	-	-
TOTAL	2	2	-	-	-

RODENT CONTROL

Prevention of Damage by Pests Act, 1949.

(1) Statistics

No. of complaints received and dealt with - 100
No. of premises surveyed and action taken - 1501
No. of premises treated - 518

The total number of properties in the Borough is 4,713. This includes 67 agricultural properties.

(2) Organisation

A free service is provided to Domestic premises. Business, agricultural and other premises are treated on a repayment basis. A large amount of work is done on the Council's own properties.

(3) Local Authority's Properties

During the year Chantry Street Depot and the Borough Market Yard have been maintained free of infestation by the use of permanent warfarin baiting points

The Sewage Works and Penton Mewsey tip have been treated quarterly. Infestation of the former has been reduced to a low level. The latter presents a more difficult problem and rodent control there costs the Council a great deal of money. This is due to the fact that the tip is also used as a site for stacked timber. The timber provides ready made homes for the rats and the tipping provides them with a daily food supply.

(4) Developments during the year

(i) Warfarin

The new anti-coagulant rodenticide warfarin was tried and came into general use during the year. It was found to be very successful enabling more work to be done with the same amount of labour. Briefly the technique is as follows:-

<u>1st. day</u>	A large number of protected 4 ozs. points are laid throughout the infested area.
<u>2nd. - 3rd. day</u>	A detailed inspection is carried out and points where no feeding is taking place are eliminated. The points where the rats are feeding are built up to 8-16 ozs. or more according to the degree of activity.
<u>7th. - 10th. day</u>	Activity should be finished by now. Holes etc. are filled in. Bodies are picked up.
<u>14th day</u>	A final check is made to ensure that the infestation has been completely cleared.

In difficult cases, additional visits are necessary but success is achieved in the majority of cases by the above routine.

Other methods are used where advantageous. For example D.D.T. tracking dust has been successfully used against mice. I look forward to Ministerial approval of the general use of anti-coagulant tracking dusts.

(ii) Conference at Winchester

The second development during the year was administrative. In May a conference of Local Authority representatives in Hampshire and other interested parties was addressed by Mr. McAuley-Gracie. The formation of Workable Area Committees in Hampshire was mooted here, but none had been formed at the end of the year.

SPECIAL REPORTS

Special reports were prepared for the information of the Council and professional organisations on the following matters:-

Slaughterhouses and Slaughtering;
Transport and Handling of Meat;
Disposal of Meat from Knacker's Yards;
Alcoholic Ice Cream;
Slum Clearance Proceedure.

STAFF

There were no changes among staff during the year.

The Staff of the Chief Sanitary Inspector's Department at the end of the year comprised the following members:-

Chief Sanitary Inspector and - A. R. Tarrant, M.R.San.I.,
Borough Shops Acts Inspector M.S.I.A.

Additional Sanitary Inspector - R. K. Crow, M.R.San.I., M.S.I.A.,
M.R.I.P.H.H.

Clerks - Miss J. J. Ford. (Senior Clerk)
Miss K. L. Hunt.

OUTDOOR STAFF

Rodent Operator - A. Prosser.

General Assistant - G. Maunders.
(Part-time Rodent Work)

I am indebted to my Assistant, Mr. R. K. Crow for the section on Rodent Control and wish to record my thanks to all the staff for their continued interest and support.

The Enquiry Office is attached to my department and great credit is due to the clerks for the able and courteous manner with which all enquiries have been dealt and I must include the Medical Officer's Secretary, who is always willing to relieve my office staff at any time when her duties permit.

